MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00001 — 00001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
EDITH	MAE	AIRHART	JANUARY 15, 1969	11:0 M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
FEMALE	WHITE	JULY 18, 1900	68 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
MAGNOLIA, W.VA.	U.S.A.		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
FROSTBURG	75 EAST MAIN STREET	HOUSEWIFE	OWN HOME

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	FROSTBURG	YES ☒ NO ☐	75 E. MAIN STREET

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
HENRY		KASECAMP	RUTH		TWIGG

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	N.A.	218-07-9613D	MRS. ARTHUR FEMI, MORANTOWN, R.F.D. FROSTBURG, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 week -

DUE TO, OR AS A CONSEQUENCE OF

(b) Arteriosclerotic C.V.D. — years -

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from Dec, 19 68, to Jan 15, 19 69, that (I) (~~we~~) last saw the deceased alive on 1/15 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
John B. Davis		☒	☐	☐	1/17/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
JOHN B. DAVIS, M.D.	2 BROADWAY, FROSTBURG, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	1/18/69	ECKHART CEMETERY	ECKHART ALLEGANY, MD.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
ARTHUR M. SOWERS, HAFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG		JAN 23 1969	Charles Jorge

Marthur M. Sowers

VR A15 (4) 30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00002 00002

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Estella		Balsley	January 12, 1969 at 11:50 PM	P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
Female	White	6/29/1871	97 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Virginia	U. S. A.	WIDOWED [X]	Allegany County Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Allegany County Infirmary	Housewife	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany	Cumberland	YES [X] NO [ ]	129 Mary Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Richard		Balsley	Charity		Diddle

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	218-12-3228	JI-1 Allegany County Infirmary records	P.O.Box 599, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute renal insufficiency — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Chr. ASHD with CHF — many years

DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis — many years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from July 14, 1967, to Jan. 12, 1969, that (I) (we) last saw the deceased alive on Jan. 11, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
John A. Tepper	MD	[X]	[ ]	[ ]	1-13-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
John A. Tepper MD	Memorial Hospital, Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Jan. 15, 1969	Rose Hill Cemetery	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.		JAN 16 1969	Clinton Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (A)
30M REV 7/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00003 00003

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: Jessie	Middle: June	Last: Barkman	2a. DATE OF DEATH Month Day Year: January 24, 1969	2b. HOUR: 5.10 P.M.
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: June 12, 1890	6. AGE (In years last birthday): 78 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Allegany, Cumberland, Md.		
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 413 Pulaski Street	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housekeeper	12b. KIND OF BUSINESS OR INDUSTRY: -At Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES ☑ NO ☐	13e. STREET AND NUMBER: 413 Pulaski St.	
14. FATHER'S NAME First: James	Middle: Oliver	Last: Hinkle	15. MOTHER'S MAIDEN NAME First: Susan	Middle: Virginia	Last: Willison
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 217-18-4534	17. INFORMANT: Mrs. Ruth Browning	Address: 413 Pulaski St Cumberland, Md		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 7 days

DUE TO, OR AS A CONSEQUENCE OF

(b) Hypertensive cardiovascular disease — 20 yrs.

DUE TO, OR AS A CONSEQUENCE OF

(c) Diabetes mellitus — 20 yrs.

2509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Generalized arteriosclerosis

19a. DATE OF OPERATION: none	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: none	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.): None	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.): None	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I **certify** that (I) (this hospital) attended the deceased from Jan. 19, 1968, to Jan. 24, 1969, that (I) (we) last saw the deceased alive on Jan. 24, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 5.10 P.M.

22b. SIGNATURE: James P. Hallinan M.D. DEGREE: ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED: Jan. 25, 1969

22d. PHYSICIAN'S NAME (Type): James P. Hallinan M. D. — 22e. ADDRESS: 140 Bedford St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 1/27/69	23c. NAME OF CEMETERY OR CREMATORY: RoseHill Cemetery	23d. LOCATION (City or Town): Cumberland	(County): Allegany (State): Maryland
24. FUNERAL DIRECTOR: Silcox-Merritt Funeral Service	ADDRESS: Cumberland, Md.	25a. REC'D BY REGISTRAR DATE: JAN 27 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

VR A15 (4) 30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print): First EVA Middle M. Last BEEMAN
2a. DATE OF DEATH: Month 1/ Day 29/ Year 1969
2b. HOUR: 8 P M
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: 3/1/1903
6. AGE (In years last birthday): 65 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): MD.
7b. CITIZEN OF WHAT COUNTRY? USA.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: Allegany Md.
10. CITY OR TOWN OF DEATH: Frostburg
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Miners Hospital
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): House wife
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD.
13b. COUNTY: Allegany
13c. CITY OR TOWN: Midland
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET AND NUMBER: None
14. FATHER'S NAME: First George Middle H. Last Stevenson
15. MOTHER'S MAIDEN NAME: First Sarah Middle E. Last Winters
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Clinton Beeman (Husband) Address: Midland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HCVD C Cerebral accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 Weeks
DUE TO, OR AS A CONSEQUENCE OF (b) repeated cerebral accidents — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4122
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from Jan 15, 19 69, to Jan 29 19 69, that (I) (~~we~~) last saw the deceased alive on Jan 29 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: John B. Davis, DEGREE ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED: 1/30/69
22d. PHYSICIAN'S NAME (Type): John B. Davis
22e. ADDRESS: Frostburg, Md. 21532

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 2/1/1969
23c. NAME OF CEMETERY OR CREMATORY: Memorial Park
23d. LOCATION (City or Town) (County) (State): Frostburg, Md.
24. FUNERAL DIRECTOR: George Eichhorn
ADDRESS: Lonaconing, Md.
25a. RECEIVED BY REGISTRAR DATE: FEB 3 1969
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV. 1/68

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00005

Item23 FilmG409 1/29/69 kk

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
DEANA	W.	BITTINGER	1	10	69	2:30P

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
FEMALE	WHITE	5-30-68	— YRS.	7	

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
PENNSYLVANIA	U.S.A.		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL		

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
PENNA.		MEYERSDALE	YES ☐ NO ☒	RT. 4

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
HERMAN		BITTINGER	CATHERINE		BEEMAN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
		MEMORIAL HOSPITAL	CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumonia, fulminating — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 486X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Downs Syndrome - Cong Heart Disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 1/3, 19 69, to 1/10, 19 69, that (I) (we) last saw the deceased alive on 1/10 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Robert J. Dawson		☒	☐	☐	1/13/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. ROBERT J. DAWSON	CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	1/13/1969	St. John's Cemetery	Meyersdale Som. Pennsylvania

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
William C. Price Fun. Home, Meyersdale, Penna.	JAN 22 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00006

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
HARRY	C.	BROOKS	JANUARY	1	69	4:38 A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
MALE	~~WHITE~~ Colored	5/7/98	70 YRS		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
W. VA.	USA		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL		

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	ALLEGANY	CUMBERLAND	YES ☒ NO ☐	104 MECHANIC ST.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JOSEPH		BROOKS	BELL		BRADY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	214-05-5271	MEMORIAL HOSPITAL	CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral hemorrhage

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from [illegible], 19[illegible], to [illegible], 19[illegible], that (I) (we) last saw the deceased alive on [illegible], 19[illegible], and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED
[signature]			1/6/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
BLANE M. SCHINDLER, M.D.	43 GREENE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	12/4/69	Romney	Romney	Hampshire	W.Va.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
SHAFFER FUNERAL HOME [signature]	ROMNEY, W. VA.	JAN 8 1969	[signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

1

00007

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00007

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Mattie		Campbell	January 15 1969	240PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Female	Negro	7-15-82	86 YRS		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Virginia	Allegany, USA		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Cumberland Nursing Center	Hotel Hammersmith	Hotel

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Allegany	Cumberland	YES ☒ NO ☐	Kennedy Homes Apt. 305

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Edward		Williams	Lula		ADAMS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT Address
No	206-03-5444	Mrs. George Ashby 320 Central Ave. Cumberland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a) (b), and (c).)

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	Apoplectic Stroke	2 days
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last — DUE TO, OR AS A CONSEQUENCE OF (b)	Hypertension	2 Years
DUE TO, OR AS A CONSEQUENCE OF (c)	Arteriosclerosis, Diabetes	2 Years

4

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from 1-2, 19 69, to 1-15, 19 69, that (I) (we) last saw the deceased alive on 1-14 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
L. Krings	ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐	1-15-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	1/18/1969	Woodlawn Cemetery	Cumberland	Alleg	Md

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD. BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
John J. Hafer	230 Baltimore Ave.	JAN 20 1969	

VR A15 (1) 30M REV. 1-68

00005

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item#23aFilm#G408 1/22/69 vmp **CERTIFICATE OF DEATH** 00008

1 DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b HOUR
Edwin	Howard	Caplis	1 14 69	6:30 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
M	W.	1/18/1890	78 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
US	U.S.A.	WIDOWED ☒	Allegany Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Nursing Home Cumberland Convalescent and	Retired	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany	LaVale Cumberland	YES ☒ NO ☐	319 Algonquin Hotel Baltimore Street

14 FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
John	A.	Caplis	Bessie		Meldrum

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT	Address
No	217-07-6120	Mrs. Violet F. [illegible]	LaVale, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Uremia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) arteriolar contracted Kidneys — 1 year

DUE TO, OR AS A CONSEQUENCE OF (c) generalized arteriosclerosis — 2 years

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 3-1-, 1962, to 1-14-, 1969, that (I) (we) last saw the deceased alive on 1-14-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c DATE SIGNED
L. Kings	ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS. ☐	1-15-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS

23a BURIAL CREMATION, REMOVAL (Specify)	23b. DATE	23c NAME OF CEMETERY OR CREMATORY	23a. LOCATION (City or Town) (County) (State)
burial	1-18-69	Oak Hill Cemetery	Bradford, Pa. McKean Pa.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
John J. Hafer, Jr.	230 Balto Ave. Cumberland Md	JAN 17 1969	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1

00009

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00009

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED-NAME (Type or print)	First: CORDELLA	Middle: E.	Last: CARDER	2a DATE OF DEATH: JANUARY (Month) 30 (Day) 1969 (Year)	2b HOUR: 4:20A
3 SEX: FEMALE	4 RACE: WHITE	5 DATE OF BIRTH: 7/24/93	6 AGE (In years last birthday): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
7a BIRTHPLACE (State or foreign country): MARYLAND	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9 COUNTY OF DEATH: ALLEGANY		Md
10 CITY OR TOWN OF DEATH: CUMBERLAND	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MARYLAND	13b COUNTY: ALLEGANY	13c CITY OR TOWN: CUMBERLAND	13d INSIDE CITY LIMITS? YES [X] NO [ ]	13e STREET AND NUMBER: RT. 3, BEDFORD RD.	
14 FATHER'S NAME First: GEORGE	Middle	Last: LONG	15 MOTHER'S MAIDEN NAME First: MARY	Middle	Last: HAYES
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17 INFORMANT Address: MEMORIAL HOSPITAL CUMBERLAND, MD.			

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c)).

PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Carcinomatosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 mo.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): —

DUE TO, OR AS A CONSEQUENCE OF

(c): —

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Arteriosclerosis

19a DATE OF OPERATION: —	19b CONDITION FOR WHICH OPERATION WAS PERFORMED: —	20a AUTOPSY? YES [ ] NO [X]	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —
21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While at work [ ] Not while at work [ ]	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No.	City or Town: Cumb	County: Alleg	State: Md

22a. **I certify** that (I) (this hospital) attended the deceased from 11/17/69, 19___, to 1/30/69, 19___, that (I) (~~we~~) last saw the deceased alive on 1/30/69 19___, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (did not) view the body after death.

22b SIGNATURE: H. Williams, M.D. — DEGREE: ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS [ ] — 22c DATE SIGNED: 1/31/69

22d PHYSICIAN'S NAME (Type): DR. R. J. WILLIAMS — 22e ADDRESS: 122 S. CENTRE ST. CUMBERLAND, MD.

23a BURIAL, CREMATION REMOVAL (Specify): Burial	23b DATE: Feb. 1, 1969	23c NAME OF CEMETERY OR CREMATORY: St. Michael's Cath Cem.	23d LOCATION (City or Town): Frostburg,	(County): Alleg	(State): Md
24 FUNERAL DIRECTOR: John J. Hafer, Jr.	ADDRESS: 230 Balto Ave. Cumberland Md	25a RECD. BY REGISTRAR DATE: FEB 3 1969	25b REGISTRAR'S SIGNATURE: [illegible]		

VR AIS 3-1
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month Day Year	2b HOUR
GRACE	E.	CASSEN	JANUARY 9, 1969	6:05PM

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN
FEMALE	WHITE	6-18-94	74 YRS.		

7b BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	U. S. A.	NEVER MARRIED [X]	ALLEGANY Md

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	NONE	NONE

13a USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES [X] NO [ ]	SYLVAN RETREAT

14. FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
UNKNOWN		CASSEN	EMMA		HILLEARY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT	Address
NO		219 54 2096		MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

		APPROX MATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pneumonia	7 days
DUE TO, OR AS A CONSEQUENCE OF (b)	Congestive Heart failure	14 days
DUE TO, OR AS A CONSEQUENCE OF (c)	Arteriosclerotic Heart Disease	yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING (DR CONTRIBUTING / CAUSE OF DEATH) (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d INJURY OCCURRED While at work / Not while at work	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D. No	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from 11-5, 1968 to 11-7, 1968, that (I) (we) last saw the deceased alive on 11-7, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	22c. DATE SIGNED
George M. Simons	ATTENDING PHYS [ ] MED DIRECTOR [X] STAFF PHYS [ ]	11/9/69

22d PHYSICIAN'S NAME (Type)	22e ADDRESS
DR. GEORGE M. SIMONS	CUMBERLAND, MD.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	JAN. 12, 1969	ROSE HILL CEMETERY	CUMBERLAND, MD.

24 FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR	25b REGISTRAR'S SIGNATURE
BYRON KIGHT	CUMBERLAND, MD.	JAN 16 1969	Eleanor Yingling

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00012

CERTIFICATE OF DEATH

00011

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print) First: MARY	Middle: VERONICA ~~HK~~	Last: CHANEY	2a. DATE OF DEATH Month: JANUARY Day: 10, Year: 1969	2b. HOUR 9:05 PM	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 11-6-1899	6. AGE (In years last birthday) 69 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): W. VA.	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md.		
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and number): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY: OWN HOME		
13a. USUAL RESIDENCE (Where deceased lived before admission) STATE: W. VA.	13b. COUNTY: MINERAL	13c. CITY OR TOWN: RIDGELEY	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: RT. 1 BOX 352 A	
14. FATHER'S NAME First: WILLIAM Middle: FLETCHER Last: HARVEY		15. MOTHER'S MAIDEN NAME First: KATHERINE Middle: ELLEN Last: MURRAY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT: MEMORIAL HOSPITAL, Address: CUMB. MD.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Asystole — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 15 min

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4107

DUE TO, OR AS A CONSEQUENCE OF (b): Myocardial infarction — 8 days

DUE TO, OR AS A CONSEQUENCE OF (c): Atherosclerotic heart disease — yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. I **certify** that (I) (this hospital) attended the deceased from 1/2, 19 69, to 1/10, 19 69, that (I) (we) last saw the deceased alive on 1/10 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	MD. DEGREE	ATTENDING PHYS [ ]	MED DIRECTOR [ ]	STAFF PHYS [X]	22c. DATE SIGNED
[signature]					1/11/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. W. P. IAMES	CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Jan. 13, 1969	Terra Alta Cemetery	Terra Alta, W. Va.

24. FUNERAL DIRECTOR ADDRESS	25a. RECEIVED BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	JAN 16 1969	[signature]

VR A15 (4) 45M 1/69

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1-68

3001~

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00012

1 DECEASED NAME (Type or Print)	First	Middle	Last
	Thomas	Aloysuis	Collins

2a DATE OF DEATH KNOWN XX ESTIMATED ☐ Month 1-20-69 Day Year 19 — 2b HOUR 12:20p M

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS M.N
Male	White	Mar.11,1916	52 YRS				

2c DATE PRONOUNCED DEAD Month January Day 20, 1969 Year 19 — 2d HOUR 12:20p M

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	U.S.A.		Allegany Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY
Cumberland	DOA Sacred Heart Hosp.	Machinist helper	Textile

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Md.	Allegany	Westernport	YES ☒ NO ☐	249 Main

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Thomas	F	Collins	Playgie		Morgon

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)	If yes give wars or dates of service	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	W.W. II	217-10-7245	Aleda Collins	Westernport, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

4107

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY THROMBOSIS — " "

DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY SCLEROSIS — ------

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY?
		YES ☒ NO ☐

21a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b DATE SIGNED January 20, 1969

ADDRESS (Street, city, town, or County) CUMBERLAND, MARYLAND

23a BURIAL CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town)	(County)	(State)
Burial	1/23/69	St. Peters	Westernport,		Md.

24 FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
E J Bral	Westernport, Md.	JAN 24 1969	Juanita Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A13 14X
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00013 00013

1. DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
EDWARD	Joseph	CONWAY	01	20	69	3:45 A M

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / M N
MALE	WHITE	06-19-06	62 YRS.		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9 COUNTY OF DEATH
MARYLAND	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY COUNTY, Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	SALESMAN	RETAIL LIQUORS, INC.

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
MARYLAND	ALLEGANY	MT. SAVAGE	YES [X] NO [ ]	BOX 451, MT. SAVAGE, MD.

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
JOSEPH		CONWAY	(MC KENZIE) FLORENCE		CONWAY

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT Address
NO	214-05-5809	SACRED HEART HOSPITAL-900 SETON DR., CUMB., MD. 21502

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a) (b), and (c))

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARCINOMA OF PANCREAS — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: UNK

15'14

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d INJURY OCCURRED While at work [ ] Not while at work [ ]	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) ~~(this hospital)~~ attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 1-19 1969, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS [X]	MED DIRECTOR [ ]	STAFF PHYS [ ]	22c DATE SIGNED
L. Gelick					1-20-69

22d PHYSICIAN'S NAME (Type)	22e. ADDRESS
L. MICHAEL GELICK	126 N. SMALLWOOD ST CUMB MD

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	1/23/69	SS. Peter & Paul Cemetery	Allegany, Cumberland, Md.

24. FUNERAL DIRECTOR ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
H. Wayne George MD. 21502 GEORGE FUNERAL HOME, 202 GREENE ST., CUMB.,	JAN 27 1969	Charles Yuzer

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00014

1 DECEASED NAME (Type or Print) First	Middle	Last	2a DATE KNOWN OF DEATH / ESTIMATED — Month Day Year	2b HOUR
JOHN	CALVIN	COOK	X Jan. 6. 1969	11p M

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	2c DATE PRONOUNCED DEAD — Month Day Year	2d HOUR
MALE	WHITE	JULY 18, 1887	81 YRS			January 8, 1969	11p M

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9 COUNTY OF DEATH
Penns.	USA	X	Allegany Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY
Cumberland	Memorial Hospital-DOA	Retired Brakeman	Railroad

13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Md.	Alle any	Rawlings	YES / NO X	Route 6

14 FATHER'S NAME First Middle Last	15 MOTHER'S MAIDEN NAME First Middle Last
Theodore Cook	Mary Ellen Tipton

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT ADDRESS
no		Mrs. Regina Cook, Rawlings, Md.-Wife

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary Occlusion	Sudden
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary Sclerosis	--
DUE TO, OR AS A CONSEQUENCE OF (c)		

4109

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES / NO X

21a EXTERNAL CAUSE WAS PRIMARY / OR CONTRIBUTING / CAUSE OF DEATH	21b TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection X, Inquiry X, and in my opinion death resulted from: Natural causes X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MED CAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER X
22b. DATE SIGNED: January 6, 1969
ADDRESS (Street city town, or county): CUMBERLAND, MARYLAND

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	Jan. 9, 1969	Hyndman Cemetery	Hyndman, Penna.

24 FUNERAL DIRECTOR ADDRESS	25a RECD BY REG STRAR DATE	25b REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	JAN 9 1969	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

VR A-5ME (5)
10M REV 1/68

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00015

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00015

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, give the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers—pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: NELLIE	Middle: XX G.	Last: CRITES	2a. DATE OF DEATH: JANUARY (Month) 6 (Day) (Year) 69	2b. HOUR: 12:40	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 1-23-10	6. AGE (In years last Birthday): 58 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): W. VA.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY			Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSP.TAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPAT.ON (Kind of work done during most of working life, even if ret red): Associated With Husband	12b. KIND OF BUSINESS OR INDUSTRY: Transfer			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE: MD.	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 1114 MICHIGAN AVE.		
14. FATHER'S NAME: First CALVIN	Middle	Last TURNER	15. MOTHER'S MAIDEN NAME: First MYRTLE	Middle	Last GROVES	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT: MEMORIAL HOSP.	Address: CUMBERLAND, MD.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Metastatic adrenal Cortical Carcinoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1940

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): (Left) Carcinoma

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Carcinoma as stated above	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY: HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. I **certify** that (I) (this hospital) attended the deceased from 10-4-, 19 68, to 1-6-, 19 69, that (I) (~~we~~) last saw the deceased alive on 1-5- 19 69, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE: W. F. Williams, M.D. — DEGREE: ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS. [ ] — 22c. DATE SIGNED: 1-6-69

22d. PHYSICIAN'S NAME (Type): W. F. WILLIAMS, M. D. — 22e. ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Jan.8,1969	23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park	23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR: SCARPELLI FUNERAL HOME	ADDRESS: CUMBERLAND, MD.	25a. REC'D BY REGISTRAR: DATE JAN 9 1969	25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15
45M - 1/68

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00016

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00016

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death (Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (rev) 45M 1969

1 DECEASED NAME (Type or print)	First: WALTER	Middle: HAROLD	Last: CUTCHALL	2a DATE OF DEATH Month: 1	Day: 30	Year: 69	2b HOUR: 12:50 P M
3 SEX: MALE	4. RACE: WHITE	5 DATE OF BIRTH: 6/20/98	6 AGE (In years last birthday): 70 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.		
7a BIRTHPLACE (State or foreign country): WEST VIRGINIA	7b CITIZEN OF WHAT COUNTRY?: UNITED STATES	8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md				
10 CITY OR TOWN OF DEATH: CUMBERLAND	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL	12a USUAL OCCUPATION (Kind of work done during most of working life even if retired): TEXTILE Mechanic	12b KIND OF BUSINESS OR INDUSTRY: CELANESE MFG.				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MARYLAND	13b COUNTY: ALLEGANY	13c CITY OR TOWN: Chesaptown	13d INSIDE CITY LIMITS? YES [X] NO [ ]	13e STREET AND NUMBER: Howard St.			
14 FATHER'S NAME First: CURT	Middle:	Last: CUTCHALL	15 MOTHER'S MAIDEN NAME First: Artima	Middle: --	Last: Cunningham		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO	(If yes give war or dates of service)	16b SOCIAL SECURITY NO: 217 10 4973	17 INFORMANT: SACRED HEART HOSPITAL	Address: 900 SETON DRIVE CUMBERLAND, MD.			

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): CARDIAC ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

4 / 10

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b): MASSIVE ACUTE MYOCARDIAL INFARCTION

DUE TO, OR AS A CONSEQUENCE OF (c): ARTERIOSCLEROSIS

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES [X] NO [ ]	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e PLACE OF INJURY (AT HOME, FARM STREET FACTORY, OFFICE BUILDING ETC.)	21f LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from 1-20, 1969, to 1-30, 1969, that (I) (we) last saw the deceased alive on 1/30 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death

22b SIGNATURE: Clarence V Vincent M D	DEGREE: Consultant	ATTENDING PHYS [ ] MED DIRECTOR [ ] STAFF PHYS [ ]	22c DATE SIGNED: 1/31/69
22d PHYSICIAN'S NAME (Type): CLARENCE VINCENT, MD.	22e ADDRESS: 912 SETON DRIVE, CUMBERLAND, MD. 21502		

23a BURIAL CREMATION, REMOVAL (Specify): Burial	23b DATE: 2/2/1969	23c NAME OF CEMETERY OR CREMATORY: Restlawn Memorial Gardens	23d LOCATION (City or Town): Cumberland,	(County): Allegany	(State): Md.
24 FUNERAL DIRECTOR: H. Wayne George	ADDRESS: 21502	25a RECD BY REGISTRAR DATE: FEB 3 1969	25b REGISTRAR'S SIGNATURE: William Judge		
GEORGE FUNERAL HOME	202 GREENE ST., CUMB., MD.				

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3001.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00017

1 DECEASED-NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month Day Year	2b HOUR P
GLADYS	K.	DANIELS	JANUARY 15, 1968	12:08M

3. SEX	4 RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
FEMALE	WHITE	AUGUST 22, 1909	59 YRS.		

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED X / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	USA		ALLEGANY Md

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSP.	HOUSEWIFE	

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c. CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES X NO	132 BEDFORD ST.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
HENRY		TWIGG	(MORRISON) GERTRUDE		TWIGG

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT Address
NO		214-09-8184	HOSPITAL RECORD, 900 SETON DRIVE, CUMB., MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROX. MATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	INTESTINAL OBSTRUCTION	3 DAYS
DUE TO, OR AS A CONSEQUENCE OF (b)	MESENTERIC THROMBOSIS, EXTENSIVE	3 DAYS
DUE TO, OR AS A CONSEQUENCE OF (c)	CONGESTIVE HEART FAILURE	7 DAYS

5609

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)
RHEUMATIC HEART DISEASE, CARDIOMEGALY, AURICULLAR FIBRILLATION

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
1E14-69	INTESTIONAL OBSTRUCTION	YES / NO #	

21a. ACCIDENT WAS UNDERLYING ☐ OR CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
NONE	NONE	NONE

21d INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	NONE				

22a. I certify that (I) (this hospital) attended the deceased from AUG. 8, 19 57, to JAN. 15, 19 69, that (I) (we) last saw the deceased alive on JAN. 15, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. 12:10 P.M.

22b SIGNATURE	DEGREE	ATTENDING PHYS #	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
James P. Hallinan M.D.					1-17-69

22d PHYSICIAN'S NAME (Type)	22e ADDRESS
JAMES P. HALLINAN, M.D.	140 BEDFORD ST., CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	1/18/1969	HILLCREST BURIAL PARK CUMBERLAND, MD.	

24 FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
BYRON KIGHT	CUMBERLAND, MD.	JAN 21 1969	Charles Yonge

VR A15 (1) 30M REV. 1-68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00018 00018

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
PATIENCE	GINN	DANIELS	January 15 1969	8:23 P

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN
Female	White	February 10, 1875	93 YRS		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Virginia	U.S.A.		Allegany Md.

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Memorial Hospital	Housewife	

13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany	Cumberland	YES ☒ NO ☐	113 Grand Ave.

14. FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
Samuel		Ginn	~~XXXX~~ Annie		Marker

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT Address
No		Mrs. Edward Nield Cumberland, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Uraemia	2 wks
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO, OR AS A CONSEQUENCE OF (b)	Myocarditis	3 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)	Arteriosclerosis	10 yrs

4103

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a I certify that (I) (this hospital) attended the deceased from June, 19 50, to Jan 15, 19 69, that (I) (we) last saw the deceased alive on Jan 12 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS	MED DIRECTOR	STAFF PHYS	22c DATE SIGNED
Clay E. Durrett		☒	☐	☐	1/17/69.

22d. PHYSICIAN'S NAME (Type)	22e ADDRESS
Clay E. Durrett, Md.	236 Virginia Ave., Cumb., Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	Jan. 18, 1969	Fort Ashby Cemetery	Fort Ashby, Mineral, W.Va.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Philip B. Wendt 121 Memorial Ave., Cumb., Md.	JAN 20 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

3001J

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00019

1. DECEASED-NAME (Type or Print) First	Middle	Last
William	Lowdermilk	Darrow

2a DATE KNOWN OF DEATH / ESTIMATED ☐ Month Day Year: 1-19-69 — 2b. HOUR: 1:30p M

3 SEX	4 RACE	5 DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
Male	White	1-9-1896	73 YRS		

2c DATE PRONOUNCED DEAD: Month January Day 19, Year 19 — 2d HOUR: 2.00p M

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	U.S.A.		Allegany Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Cumberland	822 Columbia Avenue	Retired Employee-	Celanese Corp

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md	Allegany	Cumberland	YES ☒ NO ☐	822 Columbia Avenue

14 FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Samuel		Darrow	Bessie	Ellen	Lowdermilk

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16b SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS
Yes WWI	214-07-5823	Mrs. Janet Darrow	822 Columbia Ave Cumberland, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Carcinomatosis, Generalized	6 Months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — 153.0 — DUE TO, OR AS A CONSEQUENCE OF (b)	Primary Carcinoma of ascending colon	6 Months
DUE TO, OR AS A CONSEQUENCE OF (c)	with Lung Metastasis	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY?
December 1968	Carcinoma of right colon	YES ☐ NO ☒

21a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b DATE SIGNED: January 19, 1969

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	1/22/69	Frostburg Memorial Park	Frostburg Allegany Maryland

24 FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Silcox-Merritt Funeral Service	Cumberland, Md	JAN 23 1969	Florence Judge

VR A15ME (R)
10M REV. 1/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0002a

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00020

1. DECEASED NAME (Type or print) First: HENRY	Middle: L.	Last: DAVIS	2a. DATE OF DEATH Month: 01 Day: 03 Year: 69
2b. HOUR A: 2:50 M	3. SEX: MALE	4. RACE: NEGRO	5. DATE OF BIRTH: 11-29-89
6. AGE (In years last birthday): 59 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country): NORTH CAROLINA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY COUNTY, Md
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL	12a. U.S.A. OCCUPATION (Kind of work done during most of working life even if retired.): TRUCK DRIVER	12b. KIND OF BUSINESS OR INDUSTRY: COAL CO.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: 220 FULTON STREET			
14. FATHER'S NAME First: HENRY	Middle:	Last: DAVIS	15. MOTHER'S MAIDEN NAME First: (LILLY) GRACE	Middle:	Last: DAVIS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO: 217-10-6809	17. INFORMANT: SACRED HEART HOSPITAL, 900 SETON DR., CUMB., Address MD. 21502	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from Dec 31, 1968, to Jan 3, 1969, that (I) (we) last saw the deceased alive on Jan 3 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Wayne C S Beigle M.D.	DEGREE: ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]	22c. DATE SIGNED: 1-6-69	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Jan. 6, 1969	23c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery	23d. LOCATION (City or Town): Cumberland	(County): Alleg (State): Md.
24. FUNERAL DIRECTOR: HAFER FUNERAL HOME	ADDRESS: 230 BALTIMORE AVE., CUMB., MD	25a. REC'D BY REGISTRAR: JAN 8 1969	25b. REGISTRAR'S SIGNATURE: Florence Yeager	

WR 8-1-69

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00021 00021

1 DECEASED NAME (Type or Print)	First	Middle	Last
	Anna	Brenice	Dawson

2a DATE KNOWN OF DEATH [X] ESTIMATED [ ] Month Jan. Day 17 Year 1969 — 2b HOUR 5:15 PM

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN.
Female	White	March 9, 1893	75 YRS.				

2c DATE PRONOUNCED DEAD Month Jan. Day 17, Year 19 69 — 2d HOUR 5:15 PM

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
W. Va.	U. S. A.		Allegany Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Cumberland,	D. O. A. Memorial Hosp.	Housewife,	Own home

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Maryland	Allegany	Cumberland,	YES [X] NO [ ]	207 So. Lee St.

14. FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
Jeff	---	Marteney	Ida	---	Strader

16a WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17 INFORMANT ADDRESS
No,	None	Mr. Daniel M. Dawson, 207 So. Lee St. Cumb. Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY SCLEROSIS — ---

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D

EXAMINER'S NAME (Type): Benedict Skitarelic, M. D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b DATE SIGNED: Jan. 17, 1969

ADDRESS (Street, city, town, or county): Rt. # 9 Cumb. Md.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	1/20/69	Sunset Memorial Park,	Cumberland, Allegany Md.

24. FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
H. Wayne George	Cumberland, Maryland	JAN 21 1969	Beverly Judge

VR A15ME (5) 10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

0002 ~ 00022

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED-NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month Day Year	2b HOUR
GEORGE	L.	DAY	JANUARY 3 1969	3:45 PM

3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	If UNDER 1 YEAR: MONTHS / DAYS	If UNDER 24 HRS: HOURS / MIN
MALE	WHITE	12-4-06	62 YRS.		

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
W. VA.	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL		

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
W. VA.		PAW PAW	YES [ ] NO [X]	

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
DAVID		DAY	BERTIE		MC DONALD

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT Address
		MEMORIAL HOSP. CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Uremia, catheterization necessary for bilateral hydronephrosis 10 years — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4123

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

Chronic obstructive pulmonary disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to Jan, 19 69, that (I) (we) last saw the deceased alive on Jan 3 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Frederick Miltenberger M.D.	ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]	

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
FREDERICK MILTENBERGER, M.D.	122 S. GREEN ST., CUMBERLAND, MD

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	1/6/1969	Camp Hill Cem.	Paw Paw (Morgan) W. Va.

24. FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Johnson Funeral Home, Berkeley Springs, W. Va. C E Johnson	JAN 8 1969	

VS-15 (1-69)

1

30023

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00023

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: REGINA; Middle: ; Last: DELANEY	2a. DATE OF DEATH: JANUARY Month 4, Day 1969 Year	2b. HOUR: M	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: MARCH 1, 1905	6. AGE (In years last birthday): 63 YRS. IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY Md.
10. CITY OR TOWN OF DEATH: FROSTBURG	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): ROUTE 1	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): CAFETERIA MANAGER	12b. KIND OF BUSINESS OR INDUSTRY: SCHOOL
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: FROSTBURG	13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET AND NUMBER: ROUTE 1
14. FATHER'S NAME First: WILLIAM; Middle: S.; Last: DELANEY		15. MOTHER'S MAIDEN NAME First: RACHEL; Middle: ; Last: KNIPPENBERG	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214-28-6534	17. INFORMANT: WM. P. DELANEY, Address: FROSTBURG, MD. 21532	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Congestive Heart Failure — APPROX. MATE INTERVAL BETWEEN ONSET AND DEATH: 12 mos

4 or 5

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Heart Disease — 3 years

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that (I) (this hospital) attended the deceased from 6-6-, 19 61, to 1-4, 19 69, that (I) (we) last saw the deceased alive on 1-2 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Ralph W. Ballin DEGREE: ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐			22c. DATE SIGNED: 1-6-69
22d. PHYSICIAN'S NAME (Type): RALPH W. BALLIN, M. D.		22e. ADDRESS: 62 GREENE ST., CUMBERLAND, MD. 21502	

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: JAN. 7, 1969	23c. NAME OF CEMETERY OR CREMATORY: ST. MICHAEL'S CEMETERY	23d. LOCATION (City or Town): FROSTBURG, MD.	(County) (State)
24. FUNERAL DIRECTOR: J. R. DURST, FROSTBURG, MD.	ADDRESS: 21532	25a. REC'D BY REGISTRAR DATE: JAN 8 1969	25b. REGISTRAR'S SIGNATURE: Mildred Yates	

VR-A 514 (Rev. 1/68)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00024 00024

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
PHILIP	T.	DICKEL	JANUARY 26, 1969	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
MALE	WHITE	DEC. 15, 1908	60 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
FROSTBURG	D O A MINERS HOSPITAL	CONSTRUCTION	BITUMEMAKIE CONSTRUCTION

13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	MT. SAVAGE	YES [ ] NO [X]	ROUTE 1

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
CHARLES	E.	DICKEL	MARY		COLLINS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT Address
	215-10-1258	ELMER L. DICKEL, MT. SAVAGE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a) Myocardial failure, irreversible — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

402X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) Atrial flutter with complete heart block

DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive heart disease — 3 weeks

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Chronic nephritis with uremia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from Jan 4, 1969, to Jan 26, 1969, that (I) (we) last saw the deceased alive on Jan 22 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
G. Paige Strong	ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS [ ]	Jan 26, 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
A. PAIGE STRONG, M. D.	E. MAIN ST., FROSTBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	JAN. 29, 1969	ST. PATRICK'S CEMETERY	MT. SAVAGE, MD.

24. FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOSEPH R. DURST, FROSTBURG, MD. 21532	FEB 3 1969	Wilmer Yingling

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15 (1) 30M REV 1-68

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00025 00025

1 DECEASED-NAME (Type or print)	First: ROXIE	Middle: M.	Last: DODGE	2a DATE OF DEATH: 1 Month 26 Day 69 Year	2b HOUR: 12:44 A M	
3 SEX: FEMALE	4 RACE: WHITE	5. DATE OF BIRTH: 1-23-99	6. AGE (In years last birthday): 70 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	
7a BIRTHPLACE (State or foreign country): PENNA.	7b CITIZEN OF WHAT COUNTRY?: USA	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY Md			
10 CITY OR TOWN OF DEATH: CUMBERLAND	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): HOUSEWIFE	12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE: MD.	13b COUNTY: ALLEGANY	13c CITY OR TOWN: LA VALE	13d INSIDE CITY LIMITS? YES X NO ☐	13e. STREET AND NUMBER: 10 ASBURY AVENUE		
14. FATHER'S NAME First: DANIEL	Middle	Last: STULLER	15 MOTHER'S MAIDEN NAME First: (STELLA) MARGARET	Middle	Last: STULLER	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO (If yes give war or dates of service)	16b SOCIAL SECURITY NO: 214-05-5606	17 INFORMANT: HOSPITAL RECORDS	Address: 900 SETON DR. CUMBERLAND, MD.			

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

		Approximate interval between onset and death
IMMEDIATE CAUSE (a)	CARDIAC ARREST	64 MIN.
DUE TO, OR AS A CONSEQUENCE OF (b)	CORONARY INSUFFICIENCY	??
DUE TO, OR AS A CONSEQUENCE OF (c)	MYOCARDIAL FIBROSIS CORONARY ARTERIOSCLEROSIS	??

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

DIABETES MELITUS

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES ☐ NO ☐	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a **I certify** that (I) (this hospital) attended the deceased from 9-14, 1968, to 1-26, 1969, that (I) (we) last saw the deceased alive on 1-26-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE				22c DATE SIGNED
Dr. [illegible] for S.G. Weisman	MD	ATTENDING PHYS ☑	MED DIRECTOR ☐	STAFF PHYS ☐	1-26-69
22d PHYSICIAN'S NAME (Type) S. G. WEISMAN, M.D.		22e ADDRESS 59 GREENE ST., CUMBERLAND, MD.			

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	1/29/1969	Crown Crest Memorial Park	Clearfield (Clearfd) Penna.

24 FUNERAL DIRECTOR	ADDRESS	25a REC'D BY REG'STRAR DATE	25b REG'STRAR'S SIGNATURE
John J. Hafer HAFER FUNERAL HOME	Md. 230 Balto Ave Cumberland	Jan 29 1969	Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Items 13a,b,c,d, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Film 3 409 1/22/69 llw 0002b **CERTIFICATE OF DEATH** 00026

1. DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
James	W.	Duckworth Sr.	Jan 17 69	4:24 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
Male	White	Sept. 10, 1905	63 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
West Virginia	USA		Allegany County Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Allegany County Infirmary	Farming	Farming

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER
West Virginia	Allegany	Fort Ashby		1023 Shade's Lane

14. FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last
George Duckworth	Esther Travis

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	220-10-2083	Mrs. Alice Toler, 1023 Shade's Lane Cumberland Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Pneumonitis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Days.

DUE TO, OR AS A CONSEQUENCE OF (b) Ca. Obstructive Pulmonary Disease — Not Known

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO, OR AS A CONSEQUENCE OF (c) Possible Carcinoma of Lung Prostate Metastis — not Known

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Chr. Bronchitis - Arteriosclerosis, Left Following CVA. '67.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from June 2, 1969, to Jan 17, 1969, that (I) (we) last saw the deceased alive on Jan 17 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☑	MED DIRECTOR ☐	STAFF PHYS ☑	22c. DATE SIGNED
John A. Topper MD	MD				Jan 18-1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
John A. Topper MD	

23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	1/20/1969	Fort Ashby Cemetery	Fort Ashby, Mineral W. Va.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Charles E. Hafer	Charles E. Hafer, 230 Balto Ave. Cumberland Md.	JAN 21 1969	Charles Hafer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV 1/68

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3002.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00027

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
30M REV. 1-68

1 DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
WILBUR	T.	DURST	JANUARY 29, 1969	M

3 SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
MALE	WHITE	JULY 15, 1887	81 YRS.		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
MARYLAND	U.S.A.		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY
FROSTBURG	MINERS HOSPITAL	RETIRED FARMER	OWN FARM

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
MARYLAND	ALLEGANY	FROSTBURG	YES ☒ NO ☐	300 E. MAIN STREET

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
NORMAN		DURST	ANNIE		TURNER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17 INFORMANT Address
NO	213-48-6856-T	ANNA C. DURST, FROSTBURG, MD. 21532

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Myocardial Ischemia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Art. disease — 6 mos.

DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis — years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19 64, to Jan 29, 19 69, that (he) (we) last saw the deceased alive on Jan 28 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☒	MED DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
[signature]	MD				1-30-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
LESLIE R. MILES, M. D.	STATE ST., LONACONING, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	JAN. 31, 1969	MT. ZION CEMETERY	GARRETT COUNTY, MD.

24. FUNERAL DIRECTOR ADDRESS	25a RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOSEPH R. DURST, FROSTBURG, MD. 21532	FEB 3 1969	[signature] Registrar

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00028 00028

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
ELMER	G.	FREELAND	JANUARY 3 1969	5:15PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN
MALE	WHITE	10-26-02	66 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
ALLEGANY	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	Retired B & O Carman	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	ALLEGANY	CUMBERLAND	YES [ ] NO [ ]	912 MICHIGAN AVE.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
PHILIP	G.	FREELAND	SARAH	A.	MESSENGER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT Address
No	705-07-9653	MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Carcinoma Lung	10 mon
DUE TO, OR AS A CONSEQUENCE OF (b)	Carcinomatosis	2 mon
DUE TO, OR AS A CONSEQUENCE OF (c)	Uremia	3 wks

1621

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		[ ] [ ]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from Apr. , 1968 to Jan 3 , 1969, that (I) (we) last saw the deceased alive on Jan 3, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS.	MED DIRECTOR	STAFF PHYS	22c. DATE SIGNED
Clyde E. Durrett		[X]	[ ]	[ ]	1/4/69

22d. PHYSICIAN'S NAME (Type)	22e ADDRESS
DR. C.E.DURRETT	236 VIRGINIA AVE., CUMBERLAND, MD.

23a BURIAL CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	1/6/69	Rest Lawn Mem Gardens	LaVale Allegany Maryland

24. FUNERAL DIRECTOR ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Silcox-Merritt Funeral Service Cumberland, Md	JAN 7 1969	Gilmore Judge

VR 1015 (4) 4SM 9-69

Items 18-22a Film 410
3-7-69 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C023 — 00029

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print) First	Middle	Last	2a DATE KNOWN OF DEATH ESTIMATED	Month Day Year	2b HOUR
JOSEPH	HENRY	GOEBEL	X	JAN. 10, 1969	1:00p M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / M.N.	2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR
MALE	WHITE	AUG. 20, 1912	56 YRS.		Jan. 10, 1969	2:00p M

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9 COUNTY OF DEATH	
MARYLAND	USA	NEVER MARRIED X	ALLEGANY	Md
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY	
MT. SAVAGE	MT. SAVAGE	EMPLOYEE GLEN SAVAGE DAIRY FARM		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
MARYLAND	ALLEGANY	MT. SAVAGE	YES X NO	MT. SAVAGE, MARYLAND

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle Last
WILLIAM		GOEBEL	PEARL	SHAW
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS
NO			MRS LUCY E. GOEBEL	MT. SAVAGE, MARYLAND

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c))

PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Acute pulmonary congestion and edema — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24-48 hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — 746X

DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral edema — ---

DUE TO, OR AS A CONSEQUENCE OF (c) Chronic brain injury — About 3yrs.,7mos.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES XX NO

21a. EXTERNAL CAUSE WAS PRIMARY (X) OR CONTRIBUTING (X) CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR AM PM	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
	Evening May 29 1965	Pulled to ground by a calf and striking his head.	
21d INJURY OCCURRED WHILE AT WORK (X) NOT WHILE AT WORK	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No.	City or Town / County / State
	Farm		Mt. Savage / Allegany / Md.

22a **I certify** that I took charge of the remains described above, held on Autopsy (X), Inspection (X), Inquiry (X), and in my opinion death resulted from: Natural causes ( ), Accident (X), Suicide ( ), Homicide ( ), Undetermined manner ( )

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D., FACP.

CHIEF MEDICAL EXAMINER ( )
ASSISTANT MEDICAL EXAMINER ( )
DEPUTY MEDICAL EXAMINER (X)

22b. DATE SIGNED: January 10, 1969

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)	
BURIAL	JAN. 14, 1969	LAUREL HILL CEMETERY	MOSCOW MILLS ALLEGANY MD.	
24. FUNERAL DIRECTOR ADDRESS		25a REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MD.		JAN 16 1969	Charles Judge	

VR A15ME (5) 10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00030

1. DECEASED NAME (Type or print): First WILLIAM; Middle H.; Last GREEN
2a. DATE OF DEATH: Month 1 Day 19 Year 69
2b. HOUR: 1:20 P.M.
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: 9-23-1890
6. AGE (In years last birthday): 78 YRS. (If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.)
7a. BIRTHPLACE (State or foreign country): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: U. S. A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: ALLEGANY Md
10. CITY OR TOWN OF DEATH: CUMBERLAND
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Laborer
12b. KIND OF BUSINESS OR INDUSTRY: Foundry
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MARYLAND
13b. COUNTY: ALLEGANY
13c. CITY OR TOWN: CUMBERLAND
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET AND NUMBER: RT. #4, OLDTOWN ROAD.
14. FATHER'S NAME: First GEORGE; Middle; Last GREEN
15. MOTHER'S MAIDEN NAME: First MARGARET; Middle CLAUSER; Last ~~GREEN~~
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16b. SOCIAL SECURITY NO:
17. INFORMANT: MEMORIAL HOSPITAL- CUMBERLAND, MD. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Edema — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 week
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Insufficiency — 4 yrs
DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerotic Heart Disease — 4 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY: HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (At home, farm, street, factory, office building etc.)
21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. I certify that (I) (this hospital) attended the deceased from Jan 14, 19 69 to Jan 17, 19 69, that (I) (we) last saw the deceased alive on Jan 17 19 69, and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Wm Schindler MD — DEGREE: ATTENDING PHYS. [X] MED DIRECTOR [ ] STAFF PHYS [ ]
22c. DATE SIGNED: 1/20/69
22d. PHYSICIAN'S NAME (Type): DR. BLANE SCHINDLER
22e. ADDRESS: 43 GREENE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Jan.22,1969
23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery
23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR: James F. Scarpelli, Cumberland, Md. (Address)
25a. RECD BY REGISTRAR DATE: JAN 21 1969
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1-69

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0003 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00031

1 DECEASED-NAME (Type or print): First Juanita Middle Last Grim

2a. DATE OF DEATH: Month 1 Day 14 Year 69

2b. HOUR: 9:45 A.M.

3. SEX: Female

4. RACE: white

5. DATE OF BIRTH: 5-17-1911

6. AGE (In years last birthday): 57 YRS

If under 1 year: Months / Days

If under 24 hrs: Hours / Min

7a. BIRTHPLACE (State or foreign country): MARYLAND

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. COUNTY OF DEATH: ALLEGANY Md.

10. CITY OR TOWN OF DEATH: CUMBERLAND

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HSOPITAL

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE: MARYLAND

13b. COUNTY: ALLEGANY

13c. CITY OR TOWN: CUMBERLAND

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET AND NUMBER: 411 N. MECHANIC ST.,

14. FATHER'S NAME: First VIRGIL Middle Last CRAWFORD

15. MOTHER'S MAIDEN NAME: First HAZEL [illegible] Middle Last KELLER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO (If yes give war or dates of service)

16b. SOCIAL SECURITY NO: NONE

17. INFORMANT: Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Septicemia with shock

DUE TO, OR AS A CONSEQUENCE OF (b) kidney failure secondary

DUE TO, OR AS A CONSEQUENCE OF (c) to infected chemical burn right lower leg

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROX MATE INTERVAL BETWEEN ONSET AND DEATH: 5 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [X] NO [ ]

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY: HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]

21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)

21f. LOCATION Street or R.F.D. No / City or Town / County / State

22a. I certify that (I) (this hospital) attended the deceased from 1-13-, 1969, to 1-14-, 1969, that (I) (we) last saw the deceased alive on 1-13- 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Earl R. Paul DEGREE: ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (Type): EARL R. PAUL

22e. ADDRESS: 414 N. MECHANIC ST.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE: JAN. 17, 1969

23c. NAME OF CEMETERY OR CREMATORY: DAVIS MEMORIAL PARK

23d. LOCATION (City or Town) (County) (State): CUMBERLAND MD

24. FUNERAL DIRECTOR: BYRON KIGHT

ADDRESS: CUMBERLAND, MD.

25a. REGISTRAR: DATE: JAN 21 1969

25b. REGISTRAR'S SIGNATURE: [illegible] Judge

VR A15 45M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

0003~ 00032

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: LESLIE	Middle: M.	Last: GROVE	2a. DATE OF DEATH Month: 01 Day: 04 Year: 69	2b. HOUR: 3:35 A M
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 09-09-95	6. AGE (In years last birthday): 73 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY COUNTY, Md.		
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): LABORER	12b. KIND OF BUSINESS OR INDUSTRY: PAPER MILL		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: WESTERNPORT	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 420 WALNUT STREET	
14. FATHER'S NAME First: JAMES	Middle	Last: GROVE	15. MOTHER'S MAIDEN NAME First: (FAZENBAKER) HARRIETT	Middle	Last: GROVE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (Unknown): YES	(If yes, give war or dates of service): WW I	16b. SOCIAL SECURITY NO: 217-05-0432	17. INFORMANT: SACRED HEART HOSPITAL, 900 SETON DR., CUMB.,	Address: MD. 21502	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): ADENO-CA OF PROSTATE WITH METASTASES — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 YEAR
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
TERMINAL PNEUMONIA

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that (I) (this hospital) attended the deceased from 12 - 26, 19 68, to 1 - 4, 19 69, that (I) (we) last saw the deceased alive on 1 - 3 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Ralph W. Ballin DEGREE: ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS [ ]
22c. DATE SIGNED: 1 - 4 - 69
22d. PHYSICIAN'S NAME (Type): RALPH W. BALLIN, M.D.
22e. ADDRESS: 62 GREENE ST CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	1/7/69	Philos	Westernport Md

24. FUNERAL DIRECTOR: BOAL'S FUNERAL HOME, 111 CHURCH ST., WESTERNPORT — ADDRESS: MD. 21562 — E. S. Boal
25a. RECD BY REGISTRAR DATE: JAN 10 1969
25b. REGISTRAR'S SIGNATURE: Charles Yeager

VR A15 45M - 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00033

CERTIFICATE OF DEATH

00033

1. DECEASED-NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month Day Year	2b. HOUR
HAROLD	M.	HAISLIP	JANUARY 27 1969	6:45A

3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
MALE	WHITE	NOV 22, 1903	65 YRS		

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED X NEVER MARRIED WIDOWED DIVORCED	9. COUNTY OF DEATH
W. VA.	USA		ALLEGANY Md

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	RETIRED BALTIMORE AND OHIO EMPLOYE	

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
MD.	ALLEGANY	CUMBERLAND	YES X NO	906 BRENTWOOD ST.

14 FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
GEORGE		HAISLIP	ADA		MARTIN

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes no or Unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT Address
NO	705-05-5323	MRS ADA LEE HAISLIP 906 BRENTWOOD STREET

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) [illegible] — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES X NO	No autopsy

21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d INJURY OCCURRED While at work / Not while at work	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a I certify that (I) (this hospital) attended the deceased from [illegible] to 1/27/69 19___, that (I) (we) last saw the deceased alive on 1/27/69 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE [signature] RECORD ATTENDING PHYS X MED DIRECTOR STAFF PHYS

22c. DATE SIGNED 1/29/69

22d. PHYSICIAN'S NAME (Type) DR. RICHARD J. WILLIAMS

22e. ADDRESS 122 SOUTH CENTRE ST., CUMBERLAND, MD.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	JAN 30 1969	DAVIS MEMORIAL PARK	RFD# 4 CUMBERLAND ALLEGANY MD

24 FUNERAL DIRECTOR ADDRESS	25a RECEIVED BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
SILCOX-MERRITT 404 DECATUR ST CUMBERLAND MD.	JAN 30 1969	[signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless delay is necessary, please execute the certificate, writing the word 'pending' in Item 18. Give Pages 1 and 2 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form ME 5. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3003-4 — 00034

1. DECEASED-NAME (Type or Print) First: Walter	Middle: James	Last: Hardesty	2a. DATE KNOWN OF DEATH ESTIMATED ☐ Month Day Year: 1-24-69	2b HOUR: 2:35p M			
3 SEX: Male	4 RACE: White	5. DATE OF BIRTH: Mar. 29, 1902	6 AGE (In years last birthday): 66 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c. DATE PRONOUNCED DEAD: January 24, 1969	2d HOUR: 2:35p M
7a. BIRTHPLACE (State or foreign country): Maryland	7b CITIZEN OF WHAT COUNTRY?: U S A	8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md.				
10 CITY OR TOWN OF DEATH: Cumberland	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Memorial Hospital-DOA	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Retired Laborer	12b KIND OF BUSINESS OR INDUSTRY: Electronics				
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Allegany	13c CITY OR TOWN: Cumberland	13d INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: Route 1, Box 541 Valley Rd.			
14. FATHER'S NAME First: Hammill	Middle: Lee	Last:	15 MOTHER'S MAIDEN NAME First: Bertie	Middle:	Last: Hardesty		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 705-09-5317	17. INFORMANT: Rosie M Golden, Rte 1, Bx 541, Cumberland, Md	ADDRESS: Bowmans Addition				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
DUE TO, OR AS A CONSEQUENCE OF
(b): CORONARY SCLEROSIS — ---
DUE TO, OR AS A CONSEQUENCE OF
(c):

4109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES ☐ NO ☒
21a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No / City or Town / County / State

22a **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22b. DATE SIGNED: January 24, 1969
ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: Jan. 27, 1969	23c NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park	23d. LOCATION (City or Town) (County) (State): Near Cumberland Alleg Md	
24 FUNERAL DIRECTOR: John J. Hafer, Jr.	ADDRESS: 230 Balto Ave. Cumberland Md.	25a REC'D BY REGISTRAR DATE: JAN 27 1969	25b REGISTRAR'S SIGNATURE: Edward Yingling	

VR A15ME (5)
10M REV 1/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 MH 45M - 2-69

1

0003.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00035

1. DECEASED-NAME (Type or print)	First: MAE	Middle: FLORA	Middle: F.	Last: HEADLEY	2a. DATE OF DEATH: JANUARY (Month) 23 (Day) 1969 (Year)		2b. HOUR: 3:48 A.M.
3 SEX: FEMALE	4 RACE: WHITE	5. DATE OF BIRTH: 1/19/1906	6 AGE (In years last birthday): 63 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN		
7a BIRTHPLACE (State or foreign country): MARYLAND	7b CITIZEN OF WHAT COUNTRY?: USA	8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9 COUNTY OF DEATH: ALLEGANY Md				
10. CITY OR TOWN OF DEATH: CUMBERLAND	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Housewife	12b KIND OF BUSINESS OR INDUSTRY: Own Home				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MD.	13b COUNTY: ALLEGANY	13c CITY OR TOWN: CUMBERLAND	13d INSIDE CITY LIMITS? YES [X] NO [ ]	13e STREET AND NUMBER: 32 ROBERTS ST.			
14 FATHER'S NAME First: BURTON	Middle: C.	Last: APPOLD	15 MOTHER'S MAIDEN NAME First: MEADY	Middle: F. WAGNER	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: no (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT: MEMORIAL HOSPITAL, CUMBERLAND, MD. (Address)					

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART		APPROX. INTERVAL BETWEEN ONSET AND DEATH
404	IMMEDIATE CAUSE (a) Acute Left Ventricular Failure	6hrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last	DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Heart Failure	8yrs.
	DUE TO, OR AS A CONSEQUENCE OF (c) Multi valvular disease; Myocardial Fibrosis	Over 12 yrs.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Coronary Arteriosclerosis; Cholelithiasis, Liver Dysfunction

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES [ ] NO [X]	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)	
21d INJURY OCCURRED While at work [ ] Not while at work [ ]	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State	

22a I certify that (I) (this hospital) attended the deceased from _____, 1956, to 1/23/, 19 69, that (I) (we) last saw the deceased alive on Jan. 22, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS [X]	MED. DIRECTOR [ ]	STAFF PHYS. [ ]
22c. DATE SIGNED: 1-24-69				
22d PHYSICIAN'S NAME (Type): DR. S. M. JACOBSON	22e ADDRESS: 50 PERSHING ST., CUMBERLAND, MD.			

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: Jan.26,1969	23c NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park	23d LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.
24 FUNERAL DIRECTOR: SCARPELLI FUNERAL HOME, CUMBERLAND, MD. (ADDRESS)	25a. RECD BY REGISTRAR: JAN 27 1969	25b REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

3003b

CERTIFICATE OF DEATH

36636

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death (Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED-NAME (Type or print) First: CRAWFORD	Middle: C.	Last: HENDRICKSON	2a. DATE OF DEATH: JANUARY 10, 1969	2b. HOUR: 11:2 PM	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 2-6-1897	6 AGE (In years last birthday): 71 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9 COUNTY OF DEATH: ALLEGANY		Md
10 CITY OR TOWN OF DEATH: CUMBERLAND	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): RETIRED Maintanance Man	12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b COUNTY: ALLEGANY	13c CITY OR TOWN: LAVALE	13d INSIDE CITY LIMITS? YES [ ] NO [X]	13e STREET AND NUMBER: RT. 1 GRAMLICH RD	
14 FATHERS NAME First: WILLIAM	Middle:	Last: HENDRICKSON	15 MOTHERS MAIDEN NAME First: ELLEN	Middle:	Last: SMITH
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES	(If yes give war or dates of service): WW 1	16b SOCIAL SECURITY NO: 214-05-6365	17 INFORMANT: MEMORIAL HOSPITAL,	Address: CUMBERLAND, MD.	

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Coronary Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 48 hrs

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Arterio Sclerosis — 20 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES [ ] NO [X]	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While [ ] at work Not while [ ] at work	21e PLACE OF INJURY (At home, farm, street, factory, office building etc.)	21f LOCATION Street or R.F.D. No.	City or Town / County / State

22a. I certify that (I) (this hospital) attended the deceased from 1/10/69 19___, to 1/10/69 19___, that (I) (last saw the deceased alive on 1/10/69 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.

22b SIGNATURE: R. J. Williams — DEGREE: ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ] — 22c DATE SIGNED: 1/12/69

22d PHYSICIAN'S NAME (Type): R. J. WILLIAMS — 22e ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Jan. 1, 1969	23c NAME OF CEMETERY OR CREMATORY: Rest Lawn Mem. Garden	23d LOCATION (City or Town) (County) (State): Cumberland Allegany Md.	
24 FUNERAL DIRECTOR: William G. Kight	ADDRESS: Cumberland, Md	25a REGISTRAR:	DATE: JAN 16 1969	25b REGISTRAR'S SIGNATURE:

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

0003. 30637

1 DECEASED-NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month Day Year	2b. HOUR
WILHELMINA		HENDRICKSON	JANUARY 23 1969	2:00A

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
FEMALE	WHITE	6/21/23	45 YRS		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	USA	MARRIED X	ALLEGANY Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	Housekeeper	At Home

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES X NO	625 SCHRIVER AVE.

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
ROBERT		SIMONS	HADDIE		LANDIS

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17 INFORMANT Address
No	219-14-6806	MEMORIAL HOSPITAL CUMBERLAND, MD.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Lt. Ht. Lung infection [illegible] — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: [illegible]

DUE TO, OR AS A CONSEQUENCE OF

(b) Lt. Hip [illegible]

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M P.M Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D. No	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from [illegible], 19[illegible], to January 23, 19[illegible], that (I) (we) last saw the deceased alive on [illegible] 19[illegible] and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS ☐	MED DIRECTOR ☐	STAFF PHYS ☐	22c DATE SIGNED
[signature]					1/24/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. BLANE SCHINDLER	43 GREENE ST., CUMBERLAND, MD.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	1/25/69	Sunset Memorial Park	Cumberland Allegany Maryland

24. FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
SILCOX FUNERAL HOME CUMBERLAND, MD.	JAN 27 1969	[signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 4
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15-1
30M REV 2/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00038 00038

1 DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
James	Douglas	Heron	1	21	1969	8 A.M

3 SEX	4 RACE	5 DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
Male	White	May 23,1888	80 YRS.				

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
West Va	U.S.A.		Allegany Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Cumberland	630 Frederick Street	Retired -C & A Gas Company Employee	

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES [X] NO [ ]	13e STREET AND NUMBER
Maryland	Allegany	Cumberland		630 Frederick Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
John	D	Heron	Carrie	V	Simmons

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17. INFORMANT	
No	214-05-9135A	Martha Lee Heron	630 Frederick Street Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 day

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic vascular disease — 10 yrs

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Cerebro vascular accident last of Dec '63

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED While [ ] at work Not while [ ] at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from 12-21-, 1963, to 1-21-, 1969, that (I) ~~(we)~~ last saw the deceased alive on 1-17- 1969, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we) (did)~~ (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS [X]	MED DIRECTOR [ ]	STAFF PHYS [ ]	22c DATE SIGNED
Wm F. Williams					1-22-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	1/23/69	RoseHill Cemetery	Cumberland Allegany Maryland

24 FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REG STRAR DATE	25b. REG STRAR'S SIGNATURE
Silcox-Merritt Funeral Service Cumberland, Md	JAN 29 1969	J. Charles Judy

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M 1-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00039 00039

1 DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b HOUR
BEULAH		HESS	JANUARY 14 69	6:20 AM

3 SEX	4. RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
FEMALE	WHITE	8-1-25	43 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9 COUNTY OF DEATH
MARYLAND	USA	NEVER MARRIED (X)	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	Gas Sta Operator with Husband	

13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
MD.	ALLEGANY	OLD TOWN	YES / NO (X)	ROUTE 1

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
HARRY		ATHEY	HAZEL		SNYDER

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17 INFORMANT Address
No		MEMORIAL HOSPITAL CUMBERLAND, MD.

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Acute myocarditis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days

4123

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) Interstitial pneumonitis — 10 days

DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

Diabetes mellitus

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY?	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES / NO (X)	

21a ACCIDENT WAS UNDERLYING / OR CONTRIBUTING / CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)

21d INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a **I certify** that (I) (this hospital) attended the deceased from 1-10-, 1969, to 1-14, 1969, that (I) (we) last saw the deceased alive on 1-14 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Vernon P. Dross	ATTENDING PHYS (X) / MED DIRECTOR / STAFF PHYS	1-14-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. V. DROSS	1909 FREDERICK ST. CUMBELAND, MD.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)	
Burial	Jan. 16, 1969	Sunset Memorial Park	Near Cumberland	Alleg Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b REGISTRAR'S SIGNATURE
John J. Hafer, Jr.	230 Balto Ave Cumberland Md.	JAN 17 1969	Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00040 00040

1 DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b HOUR
HERLEN	NEWTON	HOLLER	01 31 69	1:20 PM

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
MALE	WHITE	03-08-04	64 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
PENNSYLVANIA	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY COUNTY, Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	CEMENT MASON	

13a USUAL RESIDENCE (Where deceased lived if inst.tution Res dence before admission) STATE	13b COUNTY	13c. CITY OR TOWN	13d INSIDE CITY LIMITS?	13e. STREET AND NUMBER
PENNSYLVANIA		BOYNTON	YES [ ] NO [ ]	

14. FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
NEWTON		HOLLER	(STEELE) MARY		HOLLER

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown	(If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT	Address
NO		206-03-2106	SACRED HEART HOSPITAL, 900 SETON DR., CUMB.,	MD. 21502

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac arrest	Immediate
DUE TO, OR AS A CONSEQUENCE OF		
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last	(b) Complete Left Bundle Branch Block	?
DUE TO, OR AS A CONSEQUENCE OF		
	(c) Cardiac Decompensation	3 wks. ?

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Pulmonary Embolus; Antero Septal Infarction Previous to 12/23

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO [X]	

21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d INJURY OCCURRED While at work [ ] Not while at work [ ]	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a **I certify** that (I) (this hospital) attended the deceased from 1/24/ , 19 69 , to 1/31/ , 19 69 , that (I) (we) last saw the deceased alive on 1/30/ 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c DATE SIGNED
S.M. Jacobson M.D.		[X]	[ ]	[ ]	1-31-69

22d PHYSICIAN'S NAME (Type)	22e ADDRESS
S.M. JACOBSON, M.D.	50 PERSHING ST., CUMB., MD. 21502

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR ~~CREMATORY~~	23d LOCATION (City or Town) (County) (State)
BURIAL	2-3-69	SALISBURY I.O.O.F.	SALISBURY - SOMERSET PA.

24 FUNERAL DIRECTOR ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
THOMAS FUNERAL HOME, SALISBURY, PENNSYLVANIA	FEB 5 1969	Thomas Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

VR A15 (4) 45M - 1/69

1

00041

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00041

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-5 14
45M 1-69

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
ANNA	May M.	HOWDYSHELL	01	23	69	12:50A

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN
FEMALE	WHITE	05-09-88	80 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
PENNSYLVANIA	U.S.A.		ALLEGANY COUNTY, Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	Housewife	Own Home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES [X] NO [ ]	121 OAK STREET

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
FRANK		CHAMBERLAIN	Harriet		Chadwick

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	800 00 6064	SACRED HEART HOSPITAL, 900 SETON DR., CUMB.,	MD. 21502

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 WEEKS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4124

DUE TO, OR AS A CONSEQUENCE OF (b) ACVD — 3 YEARS

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

LYMPHATIC LEUCEMIA

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a. ACCIDENT WAS UNDERLYING	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
[ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	HOUR A.M. P.M Month Day Year 19	

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from 11 - 4, 19 58, to 1 - 23, 19 69, that (I) (we) last saw the deceased alive on 1 - 22 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS	MED DIRECTOR	STAFF PHYS	22c. DATE SIGNED
Ru Burin · M.D.		[X]	[ ]	[ ]	1-23-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
R.W. BALLIN, M.D.	62 GREENE ST., CUMB., MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Jan.25,1969	Hillcrest Burial Park	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
SCARPELLI FUNERAL HOME, 108 VA. AVE., CUMB., MD	JAN 27 1969	Winston Judge

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00042 00042

1 DECEASED-NAME (Type or Print) First	Middle	Last
Doris	Ann	Huffman

2a DATE KNOWN OF DEATH ESTIMATED ☐ Month Day Year: Jan. 10, 1969 — 2b HOUR: 4:15 P M

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN
Female	White	Aug. 14, 1936	32 YRS				

2c DATE PRONOUNCED DEAD Month Day Year: JANUARY 10, 1969 — HOUR: 4:15 P M

7a. BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9 COUNTY OF DEATH
Maryland	USA		Allegany Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Cumberland	MEMORIAL HOSPITAL-DOA	Nurses Aid	Hospital

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Md.	Allegany	Cumberland	YES ☒ NO ☐	413 Grand Ave.

14. FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last
Dailey Howdyshell	Marie Slater

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17 INFORMANT ADDRESS
no	219-34-5913	Mother Mrs. Marie Howdyshell, Cumberland, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CRUSHED SKULL

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last

(b) (STRUCK BY FREIGHT TRAIN)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month Day Year HOUR PM	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
	3:45 P M 1-10-69	Struck by Freight train on RR crossing

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R F D. No City or Town County State
	RR crossing	Crossing-Avirett Ave. Cumberland, All. Md.

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M D

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b DATE SIGNED: January 10, 1969

ADDRESS (Street, city, town, or county): Cumberland, Md.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	Jan. 13, 1969	Rio Cemetery	Rio, W. Va.

24 FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	JAN 15 1969	Florence Judge

VR A15ME (5) 10M REV 1/68

1

00043

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 1, Film G409 2/19/69 cac

CERTIFICATE OF DEATH

00043

1 DECEASED NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month Day Year	2b HOUR AM/PM
BABY Diana	GIRL Carol	HUGHES	JANUARY 7, 1969	4:10

3 SEX	4. RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN
FEMALE	WHITE	1-7-1969	NB YRS		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH
MD.	USA		ALLEGANY Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	None	None

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
MD.	ALLEGANY	CUMBERLAND	YES ☒ NO ☐	5 MT. VERNON PLACE

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
WILLIAM	R.	HUGHES	CAROLINA	M	EASTON

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT Address
No	None	MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Respiratory failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

7760 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) Anoxia

DUE TO, OR AS A CONSEQUENCE OF (c) Meconium Aspiration

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☒ NO ☐	

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)

21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State

22a I **certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS. ☒	MED DIRECTOR ☐	STAFF PHYS. ☐	22c DATE SIGNED
Robert D. Brodell M.D.					

22d. PHYSICIAN'S NAME (Type)	22e ADDRESS
DR. ROBERT BRODELL	500 GREENE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	Jan. 8, 1969	Sunset Memorial Park	Cumberland Allegany Md.

24. FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
William G. Kight Cumberland, Md.	JAN 10 1969	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Items 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A05 (4) 5M 1/69

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00044

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00044

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)	First	Middle	Last
	William	Mason	Judy

2a. DATE KNOWN OF DEATH ESTIMATED ☐ Month Jan. Day 27, Year 1969 — 2b. HOUR 1:55 P.M.

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN
Male	White	Oct. 4, 1894	74 YRS				

2c. DATE PRONOUNCED DEAD Month Jan. Day 27, Year 19 69 — 2d. HOUR 1:55 P.M.

7a. BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
W. Va.	U. S. A.		Allegany Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY
Cumberland,	V. O. A. Memorial Hosp.	Stationary Fireman	Potomac Edison

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany	Cumberland,	YES ☒ NO ☐	736 Greene St.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
George	K.	Judy	Mary	A.	Harman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS
Yes,	W. W. # 1	217-10-9584	Mrs. Violet M. Judy	736 Greene St. Cumb. Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CORONARY OCCLUSION,	SUDDEN
DUE TO, OR AS A CONSEQUENCE OF (b)	CORONARY SCLEROSIS	---
DUE TO, OR AS A CONSEQUENCE OF (c)		

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY?
		YES ☐ NO ☒

21a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M. D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county) Rt. # 9 Cumberland, Md.

22b DATE SIGNED Jan. 27, 1969

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	1/30/69	Sunset Memorial Park,	Cumberland, Allegany, Md.

24 FUNERAL DIRECTOR ADDRESS	25a RECEIVED BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
H. Wayne George Cumberland, Maryland	JAN 30 1969	

VR A15ME (5) 10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

0004-69 00045

1 DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
KATHERINE	NMI	KERNS	1 11 69	4:25 PM

3 SEX	4. RACE	5 DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
FEMALE	WHITE	8 26 07	61 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9 COUNTY OF DEATH
MISSOURI	USA		ALLEGANY Md.

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND, MD.	SACRED HEART HOSPITAL	HOUSEWIFE	

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES [X] NO [ ]	212 CECELIA STREET

14 FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last
PHILLIP CAMPBELL	ELIZABETH (MOBLEY) CAMPBELL

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17 INFORMANT	Address
NO	NONE	HOSPITAL RECORDS	900 SETON DRIVE CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cancer of endometrium with	1 year
DUE TO, OR AS A CONSEQUENCE OF (b)	abdominal metastatic cancer	6 months
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY?	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
1967	cancer endometrium	YES [ ] NO [ ]	

21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from 3-1-, 1967, to 1-11-, 1969, that (I) (we) last saw the deceased alive on 1-10-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]	22c DATE SIGNED
L. Brings MD			1-12-69

22d. PHYSICIAN'S NAME (Type)	22e ADDRESS
DR. LEWIS BRINGS	57 GREENE STREET -CUMBERLAND, MARYLAND

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	JAN. 14, 1969	SUNSET MEMORIAL PARK	CUMBERLAND, MD.

24 FUNERAL DIRECTOR ADDRESS	25a RECEIVED BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
KIGHT'S FUNERAL HOME -309 DECATUR -CUMBERLAND, MD.	JAN 16 1969	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 5M 7/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

3004v

CERTIFICATE OF DEATH

00046

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print): First WILLIAM Middle M. Last KESNER
2a. DATE OF DEATH: Month JANUARY Day 25, Year 1969
2b. HOUR: 11:35 P.M.
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: 2-5-1922-2-5-22
6. AGE (In years last birthday): 46 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN
7a. BIRTHPLACE (State or foreign country): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: U. S. A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: ALLEGANY Md
10. CITY OR TOWN OF DEATH: CUMBERLAND
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Carman
12b. KIND OF BUSINESS OR INDUSTRY: B & O R.R.
13a. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE: MARYLAND
13b. COUNTY: ALLEGANY
13c. CITY OR TOWN: CUMBERLAND
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: 523 FRANK'S LANE
14. FATHER'S NAME First CHARLES Middle Last KESNER
15. MOTHER'S MAIDEN NAME First MARY Middle L. Last RODEHEAVER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes give war or dates of service): War II-LK
16b. SOCIAL SECURITY NO.:
17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Carcinoma of Left Lung with Metastasis
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: One year

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I **certify** that (I) (this hospital) attended the deceased from 1-23-69, 19___, to 1-25, 19 69, that (I) (we) last saw the deceased alive on 1-25-69 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Calvin Y. Hadidian DEGREE: ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED: 1-28-69
22d. PHYSICIAN'S NAME (Type): DR. CALVIN Y. HADIDIAN
22e. ADDRESS: 203 GREENE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Jan.29,1969
23c. NAME OF CEMETERY OR CREMATORY: Mt. Herman Cemetery
23d. LOCATION (City or Town) (County) (State): Cumberland, Md. Allegany
24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md.
25a. REC'D BY REG STRAR DATE: FEB 4 1969
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 A10
45M

0004

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00047

Item6 Film G408 1/13/69 kk

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
CHARLES	V	KIFER	JANUARY 5 1969	AM 3:15

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
MALE	WHITE	8-12-1899	69 68 YRS		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED X / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
PENNA.	USA	X	ALLEGANY COUNTY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	MD. WORKSHOP FOR BLIND	

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	ALLEGANY	CUMBERLAND	YES X NO	913 GRAND AVE.,

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JOHN		KIFER	MARGARET		FAHEY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No		MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Massive Subarachnoid Hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

4300

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension — 1 yr

DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis — 1 yr

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING / OR CONTRIBUTING / CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from 1/2, 19 69, to 1/5, 19 69, that (I) (we) last saw the deceased alive on 1/5 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	ATTENDING PHYS. X / MED. DIRECTOR / STAFF PHYS.	1/6/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. S. G. WEISMAN	59 GREEENE ST., BUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Jan. 8, 1968	St. Mary's Cemetery	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	JAN 9 1969	[signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 416 (11) 45M 6/69

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00049

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00048

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First: CATHERN	Middle: ANGELLA	Last: KLINK	2a DATE OF DEATH Month: 01 Day: 08 Year: 69	2b HOUR: A 12:50 M
3 SEX: FEMALE	4 RACE: WHITE	5 DATE OF BIRTH: 09-18-03	6 AGE (In years last birthday): 65 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
7a BIRTHPLACE (State or foreign country): PENNSYLVANIA	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9 COUNTY OF DEATH: ALLEGANY COUNTY Md		
10 CITY OR TOWN OF DEATH: CUMBERLAND	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): HOUSEWIFE	12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived before admission) STATE: PENNSYLVANIA	COUNTY	13c CITY OR TOWN: MEYERSDALE	13d INSIDE CITY LIMITS? YES [ ] NO [ ]	13e STREET AND NUMBER: RT. #4, BOX 238	
14. FATHER'S NAME First: PATRICK	Middle	Last: LUDDEN	15 MOTHER'S MAIDEN NAME First: (BRODENICK) CATHERYNE	Middle	Last: LUDDEN
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown): NO (If yes give war or dates of service)	16b SOCIAL SECURITY NO: 162-16-5638	17 INFORMANT: SACRED HEART HOSPITAL, 900 SETON DR., CUMB.,	Address: MD. 21502		

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Congestive Heart Failure

DUE TO, OR AS A CONSEQUENCE OF

(b): Myxedema and RHD

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 244X

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Pulmonary Emphysema

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES [ ] NO [ ]	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d INJURY OCCURRED While [ ] at work Not while [ ] at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No.	City or Town	County / State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: D. Matthew Kauffman DEGREE: MD ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]	22c DATE SIGNED: 1-8-69		
22d PHYSICIAN'S NAME (Type): M. KAUFFMAN, M.D.	22e. ADDRESS: 912 SETON DRIVE, CUMB., MD. 21502		

23a. BURIAL, CREMATION, REMOVAL, or (Other): BURIAL	23b DATE: 1/11/69	23c NAME OF CEMETERY OR CREMATORY: St PHILIP-JAMES CEME	23d LOCATION (City or Town): MEYERSDALE	(County): Som C.	(State): PA
24 FUNERAL DIRECTOR: M. A. Zeltzmanly	ADDRESS: PRICE FUNERAL HOME, MEYERSDALE, PENNSYLVANIA	25a RECD BY REGISTRAR DATE: JAN 15 1969	25b REGISTRAR'S SIGNATURE: Charles Judge		

VR A15 (4) 45M 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00049

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

1. DECEASED NAME (Type or print) First: Sarah	Middle: Mae	Last: Kriglein	2a. DATE OF DEATH @ 4:45 P.M. Month: January Day: 22, Year: 1969
2b. HOUR: P.M.			
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 3/14/1886	6. AGE (In years last birthday): 82 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Allegany County Md.
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Allegany County Infirmary	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Own Home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 306 Auburn Avenue			
14. FATHER'S NAME First: Mathew	Middle	Last: Schaffer	15. MOTHER'S MAIDEN NAME First: Catherine	Middle	Last: Heiland
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO: 220-10-9151	17. INFORMANT: DI Allegany County Infirmary records	Address: P.O. Box 599, Cumberland, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebro vascular accident — Approximate interval between onset and death: 3 weeks
DUE TO, OR AS A CONSEQUENCE OF
(b): Generalized Arteriosclerosis — 4 yrs
DUE TO, OR AS A CONSEQUENCE OF
(c): Pneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4567

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that (I) (this hospital) attended the deceased from Aug 15, 1968, to Jan 22, 1969, that (I) (we) last saw the deceased alive on 1/21, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: George M. Simons M.D. DEGREE — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐ — 22c. DATE SIGNED: 1/22/69

22d. PHYSICIAN'S NAME (Type): George M. Simons, M.D. — 22e. ADDRESS: Memorial Hospital, Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Jan. 25, 1969	23c. NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul Cemetery	23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR: James F. Scarpelli	ADDRESS: Cumberland, Md.	25a. RECD. BY REGISTRAR DATE: JAN 27 1969	25b. REGISTRAR'S SIGNATURE: Wilmer Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A 10M - 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00050

1 DECEASED NAME (Type or print)	First: NORENE	Middle: E.	Last: LARKIN	2a DATE OF DEATH Month: 01 Day: 18 Year: 69	2b HOUR: 2:00 M	
3 SEX: FEMALE	4 RACE: WHITE	5 DATE OF BIRTH: 11-02-91	6. AGE (In years last birthday): 77 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	
7a BIRTHPLACE (State or foreign country): MARYLAND	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9 COUNTY OF DEATH: ALLEGANY COUNTY, Md			
10 CITY OR TOWN OF DEATH: CUMBERLAND	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL	12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)	12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MARYLAND	13b COUNTY: ALLEGANY	13c CITY OR TOWN: FROSTBURG	13d INS OF CITY LIMITS? YES ☐ NO ☐	13e STREET AND NUMBER: RT#2, BOX 2[illegible]3, FROST., MD.		
14 FATHER'S NAME First: WILLIAM	Middle	Last: HENCKEL	15 MOTHER'S MAIDEN NAME First: (LOGSDON) EMMA	Middle	Last: HENCKEL	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): NO (If yes give war or dates of service)	16b SOCIAL SECURITY NO.: 217-54-6820	17 INFORMANT: SACRED HEARTHOSPITAL, 900 SETON DR., CMB., MD.	Address: 21502			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c))

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): LEFT VENTRICULAR FAILURE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 WEEKS

4124

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b): ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE — 5 YEARS

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): INFLUENZA

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No. City or Town County State (69)

22a **I certify** that (I) (this hospital) attended the deceased from 12 DECEMBER, 19 68, to 1-18, 19 68, that (I) (we) last saw the deceased alive on 1-18 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death

22b SIGNATURE	DEGREE	22c DATE SIGNED
R.W. Ballin M.D.	ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐	1-19-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
R.W. BALLIN, M.D.	62 GREENE ST., CUMBERLAND, MD. 21502

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	1-21-69	ST. PATRICK'S CEMETERY	MT. SAVAGE, MD.

24 FUNERAL DIRECTOR	ADDRESS	25a DATE RECEIVED BY REGISTRAR	25b REGISTRAR'S SIGNATURE
DURST FUNERAL HOME, 57 FROST AVE., 68 FROST.	MD. 21532	JAN 23 1969 DATE	

1

00052

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00051

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physicion.

TO FUNERAL DIRECTOR: After this certificate nos been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

1 DECEASED-NAME (Type or print) First: JOHN	Middle: FRANCIS	Last: LEEDY	2a. DATE OF DEATH Month 01 Day 04 Year 69 — 2b HOUR 11:55 P.M.
3 SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 06-24-96	6 AGE (In years last birthday) 72 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN
7a. BIRTHPLACE (State or foreign country): PENNSYLVANIA	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9 COUNTY OF DEATH: ALLEGANY COUNTY, Md
10 CITY OR TOWN OF DEATH: CUMBERLAND	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Rec. Thermometer	12b KIND OF BUSINESS OR INDUSTRY: RAILROAD
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MARYLAND	13b COUNTY: ALLEGANY	13c CITY OR TOWN: CUMBELAND	13d INSIDE CITY LIMITS? YES [X] NO [ ] — 13e STREET AND NUMBER: 216 S. LEE STREET
14. FATHER'S NAME First: JAMES	Middle	Last: LEEDY	15 MOTHER'S MAIDEN NAME First: (OSBORNE) ELIZABETH	Middle	Last: LEEDY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): NO (If yes give war or dates of service)	16b SOCIAL SECURITY NO: 714-05-6814	17 INFORMANT: SACRED HEART HOSPITAL, 900 SETON DR., CUMB., Address MD. 21502	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Bilateral Bronchopneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 20 days

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b): Advanced Cirrhosis of Liver — 6 mos.

DUE TO, OR AS A CONSEQUENCE OF (c): Cirrhosis

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES [ ] NO [X]	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D. No. City or Town County State	

22a. I **certify** that (I) (this hospital) attended the deceased from Nov., 1968, to Jan. 4, 1969, that (I) (we) last saw the deceased alive on 1/4 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: J.A. Pagan	DEGREE: ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]	22c DATE SIGNED: 1/7/69	
22d PHYSICIAN'S NAME (Type): J.A. PAGAN, M.D.	22e ADDRESS: 1068 NATIONAL HWY., LA VALE, MD. 21502		

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: 1/7/69	23c NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul's Cem.	23d LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.	
24 FUNERAL DIRECTOR: H. Wayne George — ADDRESS: GEORGE FUNERAL HOME, 202 GREENE ST., CUMB., MD	25a RECD BY REGISTRAR: JAN 9 1969	25b REGISTRAR'S SIGNATURE: Charles Judge		

VR A (41) 45M 69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00052 (00052)

1. DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
JOSEPH	G.	LEWIS	JANUARY 15th, 1969	4:54 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
MALE	WHITE	OCT. 1ST, 1899	69 YRS		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
MARYLAND	U.S.A.		ALLEGANY Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
FROSTBURG,	MINER'S HOSPITAL	MAINTENANCE	W. MD. R. R.

13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	FROSTBURG,	YES ☒ NO ☐	24 STOYER STREET,

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
THEOPHILUS		LEWIS	IDA		GEARY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT	Address
	217-03-1605	MRS. ELIZABETH LEWIS,	FROSTBURG, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac arrest.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4123 — DUE TO, OR AS A CONSEQUENCE OF (b)	Myocardial ischemia	12 yrs.
DUE TO, OR AS A CONSEQUENCE OF (c)	Coronary arteriosclerosis	12 yrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Emphysema, moderately severe.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (~~this hospital~~) attended the deceased from Jan. 11, 1969, to Jan 15, 1969, that (I) (~~saw~~) last saw the deceased alive on Jan 15 1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~saw~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED DIRECTOR	STAFF PHYS	22c. DATE SIGNED
Alvin J. Walters		☒	☐	☐	1/17/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
ALVIN J. WALTERS, M	48 BROADWAY, FROSTBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	1-18-69	FBG. MEMORIAL PARK	FROSTBURG, MD.

24. FUNERAL DIRECTOR	ADDRESS	25a. DATE RECD BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
JOSEPH R. DURST,	FROSTBURG, MD. 21532	JAN 20 1969	Eleanor Fogle

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (N) 30M REV. 1/68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00053

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00053

1. DECEASED NAME (Type or Print) First	Middle	Last						2a. DATE KNOWN OF DEATH ESTIMATED	Month	Day	Year	2b. HOUR
Ronald	Young	Lohr, Sr.						☒ / ☐	Jan.	31,	1969	4:40p M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS: HOURS	MIN	2c. DATE PRONOUNCED DEAD	Month	Day	Year	2d. HOUR
Male	White	1/1/1912	57 YRS.						January	31,	1969	4:40p M

7a. BIRTHPLACE (State or foreign country) Spokane Wash.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH Allegany	Md
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital--DOA	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Conducter	12b. KIND OF BUSINESS OR INDUSTRY B&O R.R.	

13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Allegany	13c. CITY OR TOWN Flintstone	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER Flintstone Rt #2

14. FATHER'S NAME First	Middle	Last		15. MOTHER'S MAIDEN NAME First	Middle	Last		
Peter Young		Lohr		Rose		Dawson		

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO. None	17. INFORMANT ADDRESS Mrs. Ronald Y. Lohr Sr. Flintstone Rt #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary Occlusion	Sudden
DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary Thrombosis, Left	"
DUE TO, OR AS A CONSEQUENCE OF (c)	Coronary Sclerosis	---

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

410

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MED CAL EXAMINER ☐

ASS STANT MED CAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED January 31, 1969

ADDRESS(Street, city, town, or co[illegible] CUMBERLAND, MARYLAND

23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/4/68	23c. NAME OF CEMETERY OR CREMATORY Davis Memo. Pk.	23d LOCATION (City or Town) Cumberland	(County) Allegany (State) Md

24 FUNERAL DIRECTOR Lowe Stein Inc.	ADDRESS Cumb. Md.	25a RECD BY REGISTRAR DATE FEB 3 1969	25b REGISTRAR'S SIGNATURE [illegible]

VR A15ME (5)
10M REV 1/68

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 65 (Rev. 5M 7/69)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00054 00054

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First: MICHAEL Middle: HUMBIRD Last: LONG	2a. DATE OF DEATH Month: 1 Day: 2 Year: 69	2b. HOUR OF DEATH 9:00 A.M.	
3 SEX: MALE	4 RACE: WHITE	5 DATE OF BIRTH: 11-25-1888	6 AGE (In years last birthday): 80 YRS. — If under year: Months / Days — If under 24 hrs: Hours / Min
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b CITIZEN OF WHAT COUNTRY?: U. S. A.	8 MARRIED ☐ NEVER MARR ED ☐ WIDOWED ☒ DIVORCED ☐	9 COUNTY OF DEATH: ALLEGANY Md.
10 CITY OR TOWN OF DEATH: CUMBERLAND	11 NAME OF HOSP TAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a USUAL OCCUPATION (Kind of work done during most of working life even f retired): Farmer	12b KIND OF BUSINESS OR INDUSTRY: Own Farm
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b COUNTY: ALLEGANY	13c CITY OR TOWN: CUMBERLAND	13d INS DE CITY LIMITS? YES ☐ NO ☒ — 13e STREET AND NUMBER: ROUTE #4,
14 FATHER S NAME First: MICHAEL Middle: Last: LONG	15 MOTHER S MAIDEN NAME First: SALLIE Middle: Last: STICKLEY		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes no or Unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT Address: MEMORIAL HOSPITAL-CUMBERLAND, MD.	

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Carcinoma of face ? — unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Carcinoma of prostate — 3 years

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2 Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 2 Jan, 19 69, that (I) (we) last saw the deceased alive on 2 Jan 19 69, and that to the (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: [signature] DEGREE — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED: 4 Jan 69

22d PHYSICIAN S NAME (Type): DR. FREDERICK MILTENBERGER — 22e ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	Jan. 4, 1969	Davis Memorial Cemetery	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	JAN 7 1969	[signature]

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00055 (00055)

1 DECEASED NAME (Type or Print) First	Middle	Last
Joseph	Michael	Malamphy

2a DATE KNOWN OF DEATH ESTIMATED ☐ Month Day Year: 1-14-69 — 2b. HOUR: 4:00 a M

3 SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN
Male	White	Aug. 24, 1924	44 YRS				

2c DATE PRONOUNCED DEAD Month Day Year: January 14, 1969 — 2d HOUR: 4:00 a M

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
W. Va.	U. S. A.		Allegany Md

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Cumberland,	Sacred Heart Hospital	Laborer,	Town of Ridgeley, W.Va.

13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
W. Va.	Mineral	Ridgeley,	YES ☒ NO ☐	Knobley Rd.

14 FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
John	M.	Malamphy	Anna	M.	Troll

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS
Yes, W.W.#2, Korean	233-34-5494	Mrs. Anna M. Malamphy	Knobley Rd. Ridgeley, W. Va.

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a) RESPIRATORY THERMAL BURNS — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 Hours

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

(b) (CONFLAGRATION OF DWELLING) — 10 Hours

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY?
		YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
	1-13-69 19 6:00	Trapped in burning dwelling

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No	City or Town	County	State
	Home	RIDGELEY,	MINERAL,	WEST VIRGINIA	

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒ — 22b DATE SIGNED: JANUARY 14, 1969

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

23a BURIAL CREMATION REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	1/17/69	SS. Peter & Paul Cem.	Cumberland, Allegany Md.

24 FUNERAL DIRECTOR ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
H. Wayne George Cumberland, Maryland	JAN 17 1969	Charles Judge

VR A15ME (5) 10M REV 1/68

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00056 00056

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
ALFRED	BRISON	MASON	JANUARY 23, 1969	PM 5:50

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
MALE	WHITE	6-10-1875	93 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	U. S. A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give STREET AND NUMBER)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	RETIRED - Custodian	Tire Industry

13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES / NO	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES [ ] NO [X]	20 WRIGHT'S AVE., GREEN BOWLING

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
BUCKNER		MASON	CLARA		WILBURN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT Address
No, (or unknown)	220-10-8749	MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinomatosis. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 years

185 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma Prostate

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

A.S. Cardiovasc. disease with gen. arteriosclerosis 10 years

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, not fy medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from 1955, 19____, to ____, 19____, that (I) (we) last saw the deceased alive on Jan. 23, 1969, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
W. A. Van Dorm M.D			[X]		

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. W. A. VANORMER	122 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	1/26/69	Hillcrest Burial Park	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
H. Wayne George Cumberland, Md.	JAN 28 1969	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A-5
45M 3/69

2 1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00057 00057

1. DECEASED NAME (Type or Print) First: Francis	Middle: Joseph	Last: McDade	2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month: Jan. Day: 3, Year: 1969	2b. HOUR M						
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: July.9,1904	6. AGE (In years last birthday): 64 YRS	IF UNDER 1 YEAR: MONTHS 5 DAYS 24	IF UNDER 24 HRS: HOURS MIN.	2c. DATE PRONOUNCED DEAD Month: Jan. Day: 3. Year: 1969	2d. HOUR M			
7a. BIRTHPLACE (State or foreign country): Frostburg,Md.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Allegany Md							
10. CITY OR TOWN OF DEATH: McCoole	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Route 220	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Retired Trackman	12b. KIND OF BUSINESS OR INDUSTRY: B.& O.R.R.							
13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Allegany	13c. CITY OR TOWN: McCoole.	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: Box.13 B R.F.D.3 Rawlings,Md.						
14. FATHER'S NAME First: Charles	Middle:	Last: McDade	15. MOTHER'S MAIDEN NAME First: Ellen	Middle:	Last: Begley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If yes, give war or dates of service): No	16b. SOCIAL SECURITY NO.	17. INFORMANT: Mrs.Margaret B.McDade (Wife)	ADDRESS: R.F.D.3 Box,13 Rawlings,Md.						

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): CORONARY SCLEROSIS — --

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [No] Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [XX]

22b. DATE SIGNED: 1-3-69,

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	1-7-69	St.Thomas Cem.	Keyser,W.Va.Mineral

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Harold W. McKenzie	Keyser,W.Va.	JAN 7 1969	[illegible]

VR A15ME (5)
10M REV 1/68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00058

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00058

1 DECEASED NAME (Type or Print)	First: Mark	Middle: Allen	Last: Mechem	2a DATE KNOWN OF DEATH [X] ESTIMATED [ ] Month Day Year: 1-21-69	2b HOUR: 12:30 AM
3 SEX: Male	4 RACE: White	5 DATE OF BIRTH: Dec. 3, 1968	6 AGE (In years last birthday): 0 YRS	IF UNDER 1 YEAR MONTHS: 1 DAYS: 18	IF UNDER 24 HRS HOURS / MIN	2c DATE PRONOUNCED DEAD Month Day Year: January 21, 1969	2d HOUR: 2:30 AM

7a BIRTHPLACE (State or foreign country): Maryland,	7b CITIZEN OF WHAT COUNTRY?: U. S. A.	8 MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]	9 COUNTY OF DEATH: Allegany Md		
10 CITY OR TOWN OF DEATH: Cumberland,	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Memorial Hospital-DOA	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): None, Infant	12b KIND OF BUSINESS OR INDUSTRY: None		
13a USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE: Maryland	13b COUNTY: Allegany	13c CITY OR TOWN: Cumberland,	13d INSIDE CITY LIMITS? YES [X] NO [ ]	13e STREET AND NUMBER: 531 Patterson Ave.	

14 FATHER'S NAME	First: Clyde	Middle: D.	Last: Mechem	15 MOTHER'S MAIDEN NAME	First: Mary	Middle: K.	Last: Cornelius	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No,	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: None,	17. INFORMANT	ADDRESS: Mr. Clyde D. Mechem, 531 Patterson Ave. Cumb. Md. 21502				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Acute Pulmonary Congestion and Edema — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Hours

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Patent Ductus Arteriosus and Foramen Ovale Congenital.

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [X] NO [ ]
21a EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [X] Inspection [X] Inquiry [X], and in my opinion death resulted from. Natural causes [XX] Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MED CAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: January 21, 1969

ADDRESS (Street, city, town, CUMBERLAND, MARYLAND

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: 1/23/69	23c NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park,	23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany Md.	
24 FUNERAL DIRECTOR: H. Wayne George	ADDRESS: Cumberland, Maryland	25a RECD BY REGISTRAR DATE: JAN 27 1969	25b REGISTRAR'S SIGNATURE: Victoria Yeager	

VR A15ME (5) 10M REV. 1/68

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00059 00059

1 DECEASED NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month Day Year	2b HOUR
KATHRYN	MARIE	MICHAELS	1 31 69	9:00 M

3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN
FEMALE	WHITE	3/31/22	48 YRS		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	HOUSEWIFE	

13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
MARYLAND	ALLEGANY	FROSTBURG	YES [ ] NO [X]	ROUTE 1 -BOX 621

14 FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
WALTER		SOLOMAN	MARY	ISA	SOLOMAN

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes no or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT	Address
NO	NONE	SACRED HEART HOSPITAL	~~900 SETON DRIVE~~ CUMBERLAND, MD.

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Pulmonary congestion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) Multiple metastatic lesions — 2 years

DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of Kidney

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO [X]	

21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a **I certify** that (I) (this hospital) attended the deceased from 1-16-, 1969, to 1-31-, 1969, that (I) (we) last saw the deceased alive on 1-31- 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Robert V Feddis	ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS. [ ]	

22d. PHYSICIAN'S NAME (Type)	22e ADDRESS
DR. ROBERT FEDDIS	500 GREENE STREET -CUMBERLAND, MARYLAND

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	2/3/69	PORTER CEMETERY	ECKHART, ALLEGANY, MD.

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
MARILOU M. SOWERS (Marilou M Sowers)	SOWERS, HAFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG	FEB 4 1969	Deputy Judge

FOR STATE HEALTH DEPT.

Item 5 Filed 1/29/69 11w 00060

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00060

1 DECEASED NAME (Type or Print) First	Middle	Last	2a DATE KNOWN OF DEATH / ESTIMATED	Month Day Year	2b HOUR
LEROY		MILLER		Jan. 22 1969	4P M

3 SEX	4. RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN.	2c DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
MALE	WHITE	Sept. 17, 1900 Jan. 22, 1969	68 YRS					Jan. 22 1969	5P M

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9 COUNTY OF DEATH
PENNA.	USA	DIVORCED [X]	ALLEGANY Md.

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	725 N. Mechanic St.	Retired Fireman	Municipal

13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b COUNTY	13c. CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
MD.	ALLEGANY	CUMBERLAND	YES [X] NO [ ]	725 N. Mechanic St.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
PERRY	V.	MILLER	RUFFINA		WHITACRE

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
No			Mr. Harold Miller	Cumberland, Md. Brother

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

7104

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY SCLEROSIS — ---

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [ ] NO [X]

20.a EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M P.M 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b DATE SIGNED: Jan. 22, 1969

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Jan. 25, 1969	Hyndman Cemetery	Hyndman, Penna.

24 FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	JAN 27 1969	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00061 CERTIFICATE OF DEATH 00061

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED-NAME (Type or print)	First: ISAAC	Middle: S.	Last: MORELAND	2a DATE OF DEATH: JANUARY (Month) 20 (Day) 1969 (Year)	2b HOUR: 3:10 A M	
3 SEX: MALE	4 RACE: WHITE	5. DATE OF BIRTH: 10-19-81	6 AGE (In years last birthday): 87 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country): W. VA.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY Md.			
10 CITY OR TOWN OF DEATH: CUMBERLAND	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSP.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): FARMER	12b KIND OF BUSINESS OR INDUSTRY: FARM			
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE: W. VA.	13b. COUNTY: MINERAL	13c CITY OR TOWN: RIDGELEY	13d INSIDE CITY LIMITS? YES ☐ NO ☒	13e STREET AND NUMBER: ROUTE #1		
14 FATHER'S NAME First: BASIL	Middle: NEWTON	Last: MORELAND	15. MOTHER'S MAIDEN NAME First: RHODA	Middle:	Last: WHITACRE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16b SOCIAL SECURITY NO: 236-58-1129	17 INFORMANT: MEMORIAL HOSPITAL	Address: CUMBERLAND, MD.			

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Congestive heart failure

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Cardiovas. Dis. — many years

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I certify that (I) (this hospital) attended the deceased from 10-18-, 1968, to 1-20-, 1969, that (I) (~~we~~) last saw the deceased alive on 1-19- 1969 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b SIGNATURE: Wm. F. Williams DEGREE	ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐	22c DATE SIGNED: 1-20-69	
22d. PHYSICIAN'S NAME (Type): W. F. WILLIAMS, M. D.	22e ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD.		

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Jan. 23, 1969	23c NAME OF CEMETERY OR CREMATORY: Levels	23d LOCATION (City or Town): Levels	(County): Hampshire (State): W. Va.
24. FUNERAL DIRECTOR: SHAFFER FUNERAL HOME	ADDRESS: ROMNEY, W. VA.	25a. REC'D BY REGISTRAR DATE: JAN 24 1969	25b REGISTRAR'S SIGNATURE: Deputy Judge	

VR A15 (4) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00062

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First: WILBERT	Middle: L.	Last: MOWEN	2a. DATE OF DEATH: Month 1 Day 7 Year 69	2b. HOUR: 7:20 AM
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 4-29-83	6. AGE (In years last birthday): 85 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY		Md
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): RETIRED * B & O Employee	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: FLINTSTONE	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: RT. 2	
14. FATHER'S NAME First: DAVID	Middle: F.	Last: MOWEN	15. MOTHER'S MAIDEN NAME First: VIRGINIA	Middle	Last: HOUCK
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: XXX	(If yes, give war or dates of service): XXX	16b. SOCIAL SECURITY NO.	17. INFORMANT: MEMORIAL HOSPITAL	Address: CUMBERLAND, MD.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Heart Failure
DUE TO, OR AS A CONSEQUENCE OF (b): Bronchopneumonia
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 485X
Arteriosclerotic heart disease
pulmonary heart disease
APPROX MATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Bronchial asthma

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. I **certify** that (I) (this hospital) attended the deceased from ____, 19 60, to 1/7, 19 69, that (I) (we) last saw the deceased alive on 1/6, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: S. G. Weisman	M.D. DEGREE	ATTENDING PHYS. ☒	MED DIRECTOR ☐	STAFF PHYS ☐	22c. DATE SIGNED: 1/8/69
22d. PHYSICIAN'S NAME (Type): DR. S. G. WEISMAN					22e. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 1/9/69	23c. NAME OF CEMETERY OR CREMATORY: Pleasant Grove Cemetery	23d. LOCATION (City or Town): Cumberland	(County): Allegany (State): Maryland
24. FUNERAL DIRECTOR: Silcox-Merritt Funeral Service.	ADDRESS: Cumberland, Md	25a. RECD BY REGISTRAR DATE: JAN 10 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

VR A15
45M - 1/68

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00063

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00063

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month Day Year	2b HOUR
ANNA	MAE	NEILSON	01 10 69	4:25 PM

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
FEMALE	WHITE	11-03-95	73 YRS		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH
WEST VIRGINIA	U.S.A.		ALLEGANY COUNTY, Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	HOUSEWIFE	

13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
MARYLAND	ALLEGANY	FROSTBURG	YES ☒ NO ☐	259 WELCH HILL

14 FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
THOMAS		DAVIS	(EISENTROUT) CLEMMIE		DAVIS

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT Address
NO	213-09-6427	SACRED HEART HOSPITAL, 900 SETON DR., CUMB., MD. 21502

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Hypostatic Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO OR AS A CONSEQUENCE OF (b) Congestive heart failure — 8 days

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive arteriosclerotic C.V.H.D.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Carcinoma left breast ? papillary, metastases

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
12/30/68	Cancer left breast	YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from 12-27, 1968, to 1-10, 1969, that (I) (we) last saw the deceased alive on 1-9, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS ☒	MED DIRECTOR ☐	STAFF PHYS ☐	22c. DATE SIGNED
Thomas F. Lewis	M.D.				1/11/69

22d PHYSICIAN'S NAME (Type)	22e ADDRESS
T.F. LEWIS, M.D.	500 GREENE ST., CUMB., MD. 21502

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR ~~CREMATORY~~	23d LOCATION (City or Town)	(County)	(State)
BURIAL	1-12-1969	FROSTBURG MEMORIAL PARK	FROSTBURG,	ALLEG.,	MD.

24 FUNERAL DIRECTOR ADDRESS	25a REGD. BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
DURST FUNERAL HOME, 57 FROST AVE., FROST., MD.	JAN 15 1969	

VR A15 45M - 1.69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

3006 — 00064

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
SARA	(WELLINGS)	NEILSON	JANUARY	3,	1969	2:00 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
FEMALE	WHITE	AUGUST 1, 1908	60 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
FROSTBURG	ROUTE 1	HOUSE WORK	OWN HOME

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	FROSTBURG	YES [ ] NO [ ]	RT. 1, BOX 51

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
GEORGE		WELLINGS	JULIA		RAE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
		MARSHALL NEILSON, RT. 1,	FROSTBURG, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Myocardial fibrillation — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Immediate

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive cardiovascular dis — 12 yr.

DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis — 18 yr.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While [ ] at work Not while [ ] at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from November, 19 59, to _____, 19 _____, that (I) (we) last saw the deceased alive on Dec 12, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Alvin J. Walters MD		[X]	[ ]	[ ]	1/3/68.

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
ALVIN J. WALTERS, M. D.	48 BROADWAY, FROSTBURG, MD. 21532

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	JAN. 5, 1969	FBG. MEMORIAL PARK	FROSTBURG, MD.

24. FUNERAL DIRECTOR	ADDRESS	25a. RECEIVING REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOSEPH R. DURST,	FROSTBURG, MD. 21532	JAN 7 1969	Beverly Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV. 1-68

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 45M - 11-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00065

CERTIFICATE OF DEATH

00065

1. DECEASED NAME (Type or print) First: SIMON	Middle: P.	Last: NEWLIN	2a. DATE OF DEATH Month: JANUARY Day: 12 Year: 1969
2b. HOUR: 5:55 AM			
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: SEPTEMBER 15, 1876	6. AGE (In years last birthday): 92 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN		
7a. BIRTHPLACE (State or foreign country): VIRGINIA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] W.DOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND, MD.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Guard	12b. KIND OF BUSINESS OR INDUSTRY: Electric
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERAND	13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: 551 WINIFRED ROAD			
14. FATHER'S NAME First: JOHN	Middle	Last: NEWLIN	15. MOTHER'S MAIDEN NAME First: CLARA Middle: Highby Last: HIGBEE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO: 217-10-9460	17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Bronchopneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 days

4 1 "

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Senile arteriosclerosis — 5 yrs

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Benign hypertrophy of prostate c obstruction

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town / County / State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19 20, to 1/12, 1969, that (I) (we) last saw the deceased alive on 1/11, 1969 and that in (my) (our) opinian death occurred on the dote and haur and from the causes stated above, (I), (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] MD	DEGREE	ATTENDING PHYS [X]	MED. DIRECTOR [ ]	STAFF PHYS. [ ]	22c. DATE SIGNED: 1/14/69
22d. PHYSICIAN'S NAME (Type): DR. S.G.WEISMAN					22e. ADDRESS: 59 GREENE STREET, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Jan. 14, 1969	23c. NAME OF CEMETERY OR CREMATORY: Philos Cemetery	23d. LOCATION (City or Town) (County) (State): Westernport, Alleg., Md.	
24. FUNERAL DIRECTOR: Philip B. Wendt	ADDRESS: 121 Memorial Ave., Cumb., Md.	25a. RECD BY REGISTRAR DATE: JAN 16 1969	25b. REGISTRAR'S SIGNATURE: [signature]	

12

00066

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00066

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with n 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

1. DECEASED NAME (Type or print) First: SAMUEL Middle: A. Last: NICHOLS
2a. DATE OF DEATH Month: 1 Day: 1 Year: 69
2b. HOUR: 11:3 A.M.
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: 8-17-1901
6. AGE (In years last birthday): 67 YRS. If under 1 year: Months / Days. If under 24 hrs: Hours / Min.
7a. BIRTHPLACE (State or foreign country): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: U. S. A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: ALLEGANY Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): R.Blacksmith H.
12b. KIND OF BUSINESS OR INDUSTRY: Railroad
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND
13b. COUNTY: ALLEGANY
13c. CITY OR TOWN: CUMBERLAND
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: 514 WOODSIDE AVE.
14. FATHER'S NAME First: BENJAMIN Middle: Last: NICHOLS
15. MOTHER'S MAIDEN NAME First: SARAH Middle: Last: MC GEE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no
16b. SOCIAL SECURITY NO: 705-07-9629
17. INFORMANT Address: MEMORIAL HOSPITAL-CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac C.H.D.
DUE TO, OR AS A CONSEQUENCE OF (b): Diabetes Mellitus
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Days / —

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION: —
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)
21f. LOCATION Street or R.F.D. No / City or Town / County / State
Cumberland Allegany Md

22a. I certify that (I) (this hospital) attended the deceased from 4/2/63, 19—, to 11/69, 19—, that (I) (we) last saw the deceased alive on 11/69 19—, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]
22c. DATE SIGNED: 1/2/69
22d. PHYSICIAN'S NAME (Type): DR. R. J. WILLIAMS
22e. ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL CREMATION, REMOVAL (Specify): Burial
23b. DATE: Jan.4,1968
23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: JAN 7 1969
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR-A-15 (4) Rev. 7/69

1

00067

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00067

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and within 72 hours after death in any event.

1. DECEASED NAME (Type or print) First / Middle / Last	MYRTLE / M. / OBERLY	2a. DATE OF DEATH Month / Day / Year	1 / 2 / 69
2b. HOUR	P 3:00 M		
3. SEX	FEMALE	4. RACE	WHITE
5. DATE OF BIRTH	4/2/96	6. AGE (In years last birthday)	72 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country)	WEST VIRGINIA	7b. CITIZEN OF WHAT COUNTRY?	USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]		9. COUNTY OF DEATH	ALLEGANY Md
10. CITY OR TOWN OF DEATH	CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	SACRED HEART HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	MARYLAND	13b. COUNTY	ALLEGANY
13c. CITY OR TOWN	WESTERNPORT	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	
13e. STREET AND NUMBER	115 GREENE STREET		
14. FATHER'S NAME First / Middle / Last	CONNOR / SHILLINGBURG	15. MOTHER'S MAIDEN NAME First / Middle / Last	EMMA HALL SHILLINGBURG
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	NO	16b. SOCIAL SECURITY NO	234 03 2668
17. INFORMANT	SACRED HEART HOSPITAL	Address	900 SETON DRIVE CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary artery disease — Approximate interval between onset and death: 3 years

DUE TO, OR AS A CONSEQUENCE OF

(b) Generalized arteriosclerosis — 3 years

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4123

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. **I certify** that (I) (this hospital) attended the deceased from 12-6-, 1968, to 1-2-, 1969, that (I) (we) last saw the deceased alive on 1-2- 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death

22b. SIGNATURE	Lewis Brings M.D.	DEGREE	ATTENDING PHYS. [X]	MED DIRECTOR [ ]	STAFF PHYS [ ]	22c. DATE SIGNED 1-3-69
22d. PHYSICIAN'S NAME (Type)	DR. LEWIS BRINGS	22e. ADDRESS	57 GREENE ST - CUMBERLAND, MD. 21502			

23a. BURIAL CREMATION REMOVAL (Specify)	Burial	23b. DATE	1/6/69	23c. NAME OF CEMETERY OR CREMATORY	Philos
23d. LOCATION (City or Town)	Westernport,	(County) Md	(State)		
24. FUNERAL DIRECTOR	E.L. Boal	ADDRESS	BOAL'S FUNERAL HOME - 111 CHURCH STREET WESTERNPORT, MD. 21562		
25a. RECD BY REGISTRAR DATE	JAN 10 1969	25b. REGISTRAR'S SIGNATURE	H. Charles Yeager		

VR A15 (1)
45M - 1/68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00065 00068

1. DECEASED NAME (Type or Print)	First	Middle	Last	2a DATE KNOWN DEATH ESTIMATED	Month	Day	Year	2b HOUR			
	CHARLES	H.	OWENS	X	JAN.	31,	1969	11:30	a M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN	2c DATE PRONOUNCED DEAD Month	Day	Year	2d HOUR
MALE	WHITE	SEPT. 18, 1909	59 YRS					JAN.	31	1969	11:30 a M
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9 COUNTY OF DEATH								
MARYLAND	U.S.A.		ALLEGANY Md								
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY								
CUMBERLAND	DOA SACRED HEART HOSPITAL	FILTERATION	CELANESE CORP.								
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e. STREET AND NUMBER							
MARYLAND	ALLEGANY	FROSTBURG	YES ☐ NO ☒	ROUTE 1							
14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last						
CHARLES	H.	OWENS	NELLIE		CAMPBELL						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS							
No		214-07-4685	NELLIE OWENS, RT. 1, FROSTBURG, MD.								

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis, generalized — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Months
DUE TO, OR AS A CONSEQUENCE OF
(b) Carcinoma of Liver — "
DUE TO, OR AS A CONSEQUENCE OF
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY?
		YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M. D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

22b DATE SIGNED: Jan. 31, 1969

ADDRESS (Street, city, town, or county): RD 9, CUMBERLAND, MD.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	2-3-69	FBG. MEMORIAL PARK	FROSTBURG, MD.

24. FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
J. R. DURST, FROSTBURG, MD.	21532	FEB 4 1969	Glenda Yingling

VR A15ME (5)
10M REV 1-68

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15-4
30M REV 1-68

00069

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00069

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)	First: CHARLES	Middle: FRANKLIN	Last: PAINTER	2a. DATE OF DEATH: Month 1 Day 6 Year 69	2b. HOUR: 10:15 AM
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 3-7-99	6. AGE (In years last birthday): 69 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): W. VA.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md		
10. CITY OR TOWN OF DEATH: CUMBERLAND,	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): RETIRED Tire room worker	12b. KIND OF BUSINESS OR INDUSTRY: Kelly Tire		
13a. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission): MARYLAND	13b. ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 122 POLK ST.	
14. FATHER'S NAME: First BARNEY	Middle	Last PAINTER	15. MOTHER'S MAIDEN NAME: First JANE	Middle A.	Last Longerbean
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (No, no, or unknown) (If yes give war or dates of service): NO	16b. SOCIAL SECURITY NO: 220-03-7439	17. INFORMANT: HOSP. REC.	Address: CUMBERLAND, MD Mrs. Gladys M. Painter, 122 Polk St. Cumb. Md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4X6X

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): pulmonary emphysema

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from 1-4-, 1969, to 1-6-, 1969, that (I) (we) last saw the deceased alive on 1-6- 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. [X]	MED. DIRECTOR [ ]	STAFF PHYS. [ ]	22c. DATE SIGNED
L Brings					1-8-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. L. BRINGS	57 Greene St. Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	1/9/69	Davis Memorial Cemetery	Cumberland, Allegany Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
GEORGES H. Wayne George Cumberland, Md.	JAN 10 1969	Charles Yoge

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1/29/69 llw ,Item#13e,FilmGL09 2

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00670

1 DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b HOUR
John	Frederick	Perdew	January	22	1969	M

3 SEX	4. RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Male	White	Dec. 9, 1906	62 YRS				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9 COUNTY OF DEATH
Maryland	U S A		Allegany Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Lonaconing	Kyle Nursing Home	Meat Cutter	Judy's Market

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e STREET AND NUMBER
Maryland	Allegany	Cumberland	YES ☒ NO ☐	112 Columbia St.

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
John	M	Perdew	Nellie		Cessna

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17 INFORMANT	Address
No		214-05-8586	Ann Perdew	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive Pulmonary Hemorrhage
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Pulmonary Fibrosis
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
517X
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
Generalized Arteriosclerosis

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES ☐ NO ☐	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from _____, 19 64, to Jan. 22 1969, that (I) (we) last saw the deceased alive on Jan. 20 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☒	MED DIRECTOR ☐	STAFF PHYS ☐	22c. DATE SIGNED
L.R. Miles Jr.					1-24-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
L.R. MILES, JR. M.D.	LONACONING MD

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	1/25/1969	Rosehill Cemetery	Cumberland	Alleg	Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
John J. Hafer, Jr.,	230 Balto Ave. Cumberland Md.	JAN 27 1969	Charles Judge

VR A15 (1)
30M REV 11-68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00071

Item8 Film 409 2/7/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00071

1

1. DECEASED-NAME (Type or print)	First: John	Middle: Gilbert	Last: Pfaff	2a. DATE OF DEATH (Month, Day, Year)	January 25, 1969 @ 3:10 P.M.	2b. HOUR: P.M.
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 7/16/1899	6. AGE (In years last birthday): 69 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Allegany County Md.			
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Allegany County Infirmary	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Male Pract. Nurse	12b. KIND OF BUSINESS OR INDUSTRY: Hospital			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Frostburg	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 200 E. Main Street		
14. FATHER'S NAME First: Gilbert	Middle	Last: Pfaff	15. MOTHER'S MAIDEN NAME First: Sara	Middle	Last: Saurbaugh	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO: 400-12-0716	17. INFORMANT: All Allegany County Infirmary records.	Address: P.O.Box 599, Cumberland Md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pneumonitis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 7 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b): Chr. A.S.H.D.E. Hypertension — many years

DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerosis — many years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Cerebral Thrombosis - hemiplegia, right & aphasia 10/66 Coronary Occlusion 1/67

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. I **certify** that (I) (this hospital) attended the deceased from 8/14/, 1967, to 1/25/, 1969, that (I) (we) last saw the deceased alive on 1/25/ 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: John A Tepper — DEGREE: ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS. [ ] — 22c. DATE SIGNED: 1-28-69

22d. PHYSICIAN'S NAME (Type): John A. Tepper M.D. — 22e. ADDRESS: Memorial Hospital, Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	JAN. 27, 1969	FROSTBURG MEM. PARK	FROSTBURG, ALLEGANY, MD.

24. FUNERAL DIRECTOR: ARTHUR M. SOWERS, SOWERS-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG — ADDRESS: Marilyn M. Sowers

25a. REC'D BY REGISTRAR DATE: FEB 3 1969 — 25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4) 30M REV. 1/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

2007 — 06672

1 DECEASED NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month Day Year	2b HOUR
Bessie		Potts	Jan 28 69	720PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN
Female	White	Jan 4, 1893	76 YRS		

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	America	WIDOWED [X]	Allegany Md.

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Cumberland	Cumberland Nursing Center	Housewife	

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES / NO	13e. STREET AND NUMBER
Md.	Allegany	Cumberland	YES [X] NO [ ]	109 Weber Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Price		Shipley	Amanda Jane		Fletcher

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT	Address
NO		215-34-4856	Rhea Smith	217 Frost Ave., Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral Vascular Accident	24 hrs.
DUE TO, OR AS A CONSEQUENCE OF (b)	Multiple Stroke Syndrome	years
DUE TO, OR AS A CONSEQUENCE OF (c)	Arteriosclerotic Cardiovascular Disease	years

4124
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
NONE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO [X]	

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a I certify that (I) (this hospital) attended the deceased from 4-9-56, 19____, to Jan., 19 69, that (I) (~~saw~~) last saw the deceased alive on 1-28-69, 19____, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE: ATTENDING PHYS [X] / MED DIRECTOR [ ] / STAFF PHYS [ ]	22c DATE SIGNED
		1-29-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
G. Overton Himmelwright, M.D.	133 Va. Ave., Cumberland, Md. 21502

23a BURIAL, CREMATION, REMOVAL OR OTHER	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	JAN 31, 1969	FAIRVIEW CHRISTIAN CEMET.	INGLESMITH BEDFORD PENNSYLVA

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Silcox Merritt	404 DECATUR ST CUMBERLAND	FEB 3 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
30M REV. 1/68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00073 00073

1 DECEASED-NAME (Type or Print) First: Myrtle	Middle: B.	Last: Ringler	2a DATE KNOWN OF DEATH ESTIMATED ☐ Month Day Year: 1-22-69	2b HOUR: 12:30 PM			
3 SEX: F	4 RACE: White	5 DATE OF BIRTH: 3/24/1896	6 AGE (In years last birthday): 72 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c DATE PRONOUNCED DEAD Month Day Year: January 22, 1969	2d HOUR: 12:30p M
7a BIRTHPLACE (State or foreign country): Pa. Somerset Co	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Co. Md.				
10 CITY OR TOWN OF DEATH: Cumberland	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Sacred Heart Hospital	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Home	12b KIND OF BUSINESS OR INDUSTRY: Home				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Penna.	13b. COUNTY: Somerset	13c CITY OR TOWN: Rural	13d INSIDE CITY LIMITS? YES ☐ NO ☒	13e STREET AND NUMBER: Grantsville, R.D. 1			
14 FATHER'S NAME First Middle Last: John Briskey		15. MOTHER'S MAIDEN NAME First Middle Last: Clara Shumaker					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b SOCIAL SECURITY NO: 206-40-8395	17 INFORMANT: Mrs Lucille Wisseman, Grantsville	ADDRESS: R.D. 1				

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c))

PART I DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	SHOCK,	12 Hours
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	CHEMICAL PERITONITIS	12 Hours
DUE TO, OR AS A CONSEQUENCE OF (c)	PERFORATED DUODENAL ULCER	12 Hours

5321

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a **I certify** that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: January 22, 1969

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	1/25/1969	Somerset Co. Memorial Park	Somerset, Somerset, Pa

24 FUNERAL DIRECTOR / ADDRESS	25a RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Stanley M Thomas Salisbury, Pa	JAN 24 1969	Charles Judge

VR A15ME (5)
10M REV 1/68

1

0007-4

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00074

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS A15 (A)
30M REV 5/68

1 DECEASED NAME (Type or print)	First: Helena	Middle: Sarah	Last: Robertson	2a DATE OF DEATH Month: Jan. Day: 27 Year: 1969		2b HOUR: 10 A.M.
3 SEX: Female	4. RACE: White	5. DATE OF BIRTH: Dec. 22, 1879	6 AGE (In years last birthday): 89 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	
7a BIRTHPLACE (State or foreign country): Md.	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md			
10. CITY OR TOWN OF DEATH: Barton	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Md.	13b COUNTY: Allegany	13c. CITY OR TOWN: Barton	13d INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER		
14 FATHER'S NAME First: Thomas	Middle: P	Last: Lyons	15. MOTHER'S MAIDEN NAME First: Sarah	Middle: Ann	Last: Morris	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17 INFORMANT: Althea Lashbaugh-Barton, Md.	Address			

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Embolus (coronary or cardiac) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes
4 +
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (b): Generalized atherosclerosis — 20 yrs.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Small gangrenous area at right knee.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State	

22a **I certify** that (I) (this hospital) attended the deceased from December 3, 19 68, to January 27, 19 69, that (I) (we) last saw the deceased alive on January 22 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: William W. Lesh MD — DEGREE: ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 1-27-69		
22d. PHYSICIAN'S NAME (Type): William W. Lesh	22e. ADDRESS: Westernport, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: 1/30/69	23c. NAME OF CEMETERY OR CREMATORY: Laurel Hill	23d LOCATION (City or Town): Moscow Mills	(County) (State): Md.
24 FUNERAL DIRECTOR: E. L. Brant	ADDRESS: Westernport, Md.	25a. RECD BY REGISTRAR DATE: JAN 30 1969	25b. REGISTRAR'S SIGNATURE: Charles Yingst	

1

00675

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00675

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Clara		Ross	Jan. 21 1969	2 A.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	Aug. 11, 1892	88 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Maryland	U.S.A.	WIDOWED [X]	Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Rinch Nurs. Home		

13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Allegany	Barton	YES [X] NO [ ]	

14. FATHER'S NAME First / Middle / Last	15. MOTHER'S MAIDEN NAME First / Middle / Last
James Norris	Mary F. Hunucher

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NK		Charles Ross-Rawlings, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Uraemia	2 hrs
DUE TO, OR AS A CONSEQUENCE OF (b)	Fibrosis of Esophagus	6 mos
DUE TO, OR AS A CONSEQUENCE OF (c)	Arteriosclerosis	5 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING / OR CONTRIBUTING / CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. I **certify** that (I) (this hospital) attended the deceased from June, 19 68 to Jan 21, 19 69, that (I) (we) last saw the deceased alive on Jan 19 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Clay Durrett		[X]	[ ]	[ ]	1/22/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Clay Durrett	Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	1/23/69	Laurel Hill	Moscow Mills, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD. BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
E. A. Beal	Westernport, Md.	JAN 24 1969	Charles Judge

VR A15 [illegible]
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00076 00076

1. DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b HOUR
Walter	Robert	Ross	Jan. 14 1969	M

3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / M.N
Male	White	May 18, 1895	73 YRS.		

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Maryland	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	Allegany Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Westernport	Rural	Farmer	Farm

13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	13b COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e STREET AND NUMBER
Md.	Allegany	Westernport	YES [ ] NO [X]	R.D. 1

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
William	M	Ross	Mary	L.	Montgomery

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17 INFORMANT	Address
	216-05-5757	Mary Ross	Westernport, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio-renal disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 mos

4121

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease — 3 yrs

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from Jan. , 19 68 , to Jan. , 19 69 , that (I) (we) last saw the deceased alive on Jan. 14 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS [X]	MED DIRECTOR [ ]	STAFF PHYS. [ ]	22c DATE SIGNED
[signature]	MD				1-16-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
James H. Wolverton, Sr	Piedmont, W.Va

23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	1/17/69	Philos	Westernport Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
[signature]	Westernport, Md.	JAN 20 1969	[signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1) 30M REV 7-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

3067. 00077

1 DECEASED-NAME (Type or print): First Mary; Middle Margaret; Last Rown
ROWAN MARY M.

2a DATE OF DEATH: JANUARY Month 28, Day 1969 Year
2b HOUR: 5.00A M

3 SEX: FEMALE
4. RACE: WHITE
5 DATE OF BIRTH: 10-11-22
6 AGE (n years last birthday): 46 YRS.
IF UNDER 1 YEAR: MONTHS; DAYS
IF UNDER 24 HRS: HOURS; MIN

7a BIRTHPLACE (State or foreign country): MARYLAND
7b CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9 COUNTY OF DEATH: ALLEGANY Md

10 CITY OR TOWN OF DEATH: CUMBERLAND
11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL
12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): HOUSE WIFE
12b KIND OF BUSINESS OR INDUSTRY: OWN HOME

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MARYLAND
13b COUNTY: ALLEGANY
13c CITY OR TOWN: CUMBERLAND
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e STREET AND NUMBER: 603 MARYLAND AVENUE

14 FATHER'S NAME First: JANNIE; Middle: E.; Last: LAMP
15 MOTHER'S MAIDEN NAME First: (SMITH) ELIZABETH; Middle; Last: LAMP

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16b SOCIAL SECURITY NO: 218-12-5144
17 INFORMANT Address: HOSPITAL RECORD, 900 SETON DRIVE, CUMB., MD.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Paraplegia due to metastatic disease of spine — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO OR AS A CONSEQUENCE OF
(b) Carcinoma of pancreas (body) — 1 yr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION: 7-30-68
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Retroperitoneal Mass
20a. AUTOPSY? YES [ ] NO [X]
20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d INJURY OCCURRED While at work [ ] Not while at work [X]
21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)
21f LOCATION Street or R.F.D. No; City or Town; County; State

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] M.D. DEGREE — ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS [ ]
22c. DATE SIGNED: 1-28-69
22d PHYSICIAN'S NAME (Type): A. J. MIRKIN, M.D.
22e. ADDRESS: 115 S. CENTRE ST., CUMBERLAND, MD. 2150

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Jan.31,1969
23c NAME OF CEMETERY OR CREMATORY: Restlawn Memorial Gardens
23d. LOCATION (City or Town) (County) (State): La Vale, Md. Allegany

24. FUNERAL DIRECTOR ADDRESS: SCARPELLI FUNERAL HOME CUMBERLAND, MD.
25a RECEIVED BY REGISTRAR DATE: FEB 4 1969
25b. REGISTRAR'S SIGNATURE: [signature] Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 45M

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of the death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 24. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

23078 — 00078

1 DECEASED-NAME (Type or Print) First	Middle	Last	2a DATE KNOWN OF DEATH / EST. MATED	Month	Day	Year	2b HOUR				
ANNA		RUPP		JAN.	9,	1969	3:15 A.M.				
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS: HOURS	M.N	2c. DATE PRONOUNCED DEAD: Month	Day	Year	2d HOUR
FEMALE	WHITE	DEC. 1, 1890	78 YRS					JAN.	9	1969	3:15 A.M.
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9 COUNTY OF DEATH								
PENNSYLVANIA	U.S.A.	WIDOWED [X]	ALLEGANY Md								
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY								
CUMBERLAND	DOA SACRED HEART	HOUSEWIFE	OWN HOME								
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c. CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER							
MARYLAND	ALLEGANY	FROSTBURG	YES [X] NO [ ]	198 GLENN STREET							
14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last						
ISAAC		WILLIAMS	MARY	ANN	JONES						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT ADDRESS									
	212-54-8086	J. CLANCY RUPP, FROSTBURG, MD. 21532									

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CORONARY OCCLUSION	SUDDEN
DUE TO, OR AS A CONSEQUENCE OF (b)	CORONARY SCLEROSIS	---
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19b. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY?
		YES [ ] NO [X]

21a EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

22b. DATE SIGNED: 1-9-69

23a BURIAL, CREMATION REMOVAL (Specify)	23b. DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	JAN. 11, 1969	FBG. MEMORIAL PARK	FROSTBURG, MD.

24. FUNERAL DIRECTOR ADDRESS	25a. RECD. BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
JOSEPH R. DURST, FROSTBURG, MD. 21532	JAN 15 1969	Elizabeth Yeager

VR A15ME (5) 10M REV 1/68

1

00079

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00079

1 DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b HOUR
MARTIN	W.	SCHAEFER	1 26 69	6:40 A M

3 SEX	4. RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
MALE	WHITE	8-30-88	80 YRS		

7a. BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
MD.	USA		ALLEGANY Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	RETIRED MINER	

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
MD.	GARRETT	GRANTSVILLE	YES ☐ NO XX	—

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
HENRY		SCHAEFER	(LEINSETTER) CHRISTINEA		SCHAEFER

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown)	(If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT	Address
NO		215-05-7194	HOSPITAL RECORDS	900 SETON DRIVE CUMBERLAND, MD.

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Massive Pulmonary infarct, bilateral — APPROX. INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) Impacted gallbladder, CAD

DUE TO, OR AS A CONSEQUENCE OF (c) Prolonged bed rest

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

Transurethral resection of prostate

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY?	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
1-20-69	Benign Prostatic hypertrophy	YES ☒ NO ☐	Yes

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from 1-9-, 1969, to 1-26-, 19 69, that (I) (we) last saw the deceased alive on 1-26- 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS ☒	MED DIRECTOR ☐	STAFF PHYS ☐	22c DATE SIGNED
Valdes M.D.					1-29-69

22d PHYSICIAN'S NAME (Type)	22e ADDRESS
JOSE L. VALDES, M.D.	ALGONQUIN HOTEL, CUMB., MD. 21502

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	1/28/69	Grantsville Cemetery	Grantsville, Garrett, Md.

24 FUNERAL DIRECTOR	ADDRESS	25a DATE RECEIVED BY REGISTRAR	25b REGISTRAR'S SIGNATURE
Newman Funeral Home	GRANTSVILLE, MD.	FEB 3 1969	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-5
45M 1-68

00080

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00080

Items 5&6 Film 408 1/15/69 kk

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
LELA	REBECCA	SCHAUB	JANUARY 5 1969	M

3 SEX	4. RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
FEMALE	WHITE	JAN. 23, 1902 1903	66 65 YRS		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
GARRETT	U.S.A.		ALLEGANY Md.

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
FROSTBURG	MINERS HOSPITAL	HOUSEWIFE	

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	FROSTBURG	YES ☐ NO ☒	ROUTE 1

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
OTHA		GARLITZ	ANNABELIE		DURST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT Address
		MISS ANN SCHAUB, FROSTBURG, MD. RT. 1, BOX 572

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c))

PART 1 DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial Ischemia	24 hrs.
DUE TO, OR AS A CONSEQUENCE OF (b)	Chronic Congestive Failure	2 yrs.
DUE TO, OR AS A CONSEQUENCE OF (c)	Generalized Arteriosclerosis	years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from ____, 1964, to Jan 5, 1969, that (I) (we) last saw the deceased alive on Jan 3 1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS ☒	MED DIRECTOR ☐	STAFF PHYS. ☐	22c DATE SIGNED
L.R. Miles M.D.					1.6.69

22d PHYSICIAN'S NAME (Type)	22e. ADDRESS
L.R. MILES JR. M.D.	LONACONING MD, 21539

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	JAN. 8, 1969	FBG. MEMORIAL PARK	FROSTBURG, MD.

24. FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOSEPH R. DURST, FROSTBURG, MD. 21532	JAN 9 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15(4)
30M REV. 11-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

3008 — 3008

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

1 DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b HOUR
(REV.) ALFRED	JESSE	SHAVER	01	05	69	12:30 PM

3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
MALE	WHITE	05-01-11	57 YRS.		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
WEST VIRGINIA	U.S.A.		ALLEGANY COUNTY, Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	REVEREND	CHURCH

13a U.S.A. RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
WEST VIRGINIA	MINERAL	WILEY FORD	YES [ ] NO [X]	Along River Avenue

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
SIMON	J.	SHAVER	(HOTTINGER) MARY	C.	SHAVER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT Address
NO	236-14-2951	SACRED HEART HOSPITAL, 900 SETON DR., CUMB., MD. 21502

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Cardio Pulmonary Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Stomach c Mets — 2 mos.

DUE TO, OR AS A CONSEQUENCE OF (c) Carcinomatosis

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 1517

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 11/10, 1968, to 1/5/69, 19—, that (I) (we) last saw the deceased alive on 1/4 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death

22b. SIGNATURE	DEGREE: ATTENDING PHYS. [X] MED DIRECTOR [ ] STAFF PHYS [ ]	22c DATE SIGNED
J.A. Pagan		1/7/69

22d. PHYSICIAN'S NAME (Type)	22e ADDRESS
J.A. PAGAN, M.D.	1068 NATIONAL HWY., LA AVLE, MD. 21502

23a BURIAL, CREMATION, REMOVAL, Specify	23b. DATE	23c NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Removal, Burial	1/7/69	Cedar Hill Cemetery	Franklin, Pendleton, W.Va.

24 FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
H. Wayne George Cumberland, Md. BROWN FUNERAL HOME, FRANKLIN, W.VA.	JAN 9 1969	Charles Judge

VR A15 (4) 45M - 1/69

[illegible] 11-10-60 [illegible]

[illegible]

[illegible] (H TTI H) [illegible]

[illegible]

[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00082 00082

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month Day Year	2b HOUR
CHARLES	E.	SHAW	JAN. 2 1968	2 P M

3 SEX	4. RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
MALE	WHITE	JAN.26,1884	84 YRS.		

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
PENNA.	USA		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	645 BEDFORD STREET	TELLER	BANKING

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIM.TS? YES ☒ NO ☐	13e STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND		645 BEDFORD STREET

14. FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last
CHARLES E. SHAW	MARY HEBENER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17 INFORMANT Address
NO	217 14 4126	MRS. NAURENE SHAW CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	Arteriosclerotic Cardio-Vasc Disease	5 yr
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO, OR AS A CONSEQUENCE OF (b)	Myocarditis & Decompensation	4 mon.
DUE TO, OR AS A CONSEQUENCE OF (c)	Coronary Heart Disease	1 yr

4123

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES ☐ NO ☐	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from Oct. 15, 1968, to Jan. 2, 1969, that (I) (we) last saw the deceased alive on Nov. 30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c DATE SIGNED
Clay E. Durrett	ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐	JAN. 3, 1968

22d PHYSICIAN'S NAME (Type)	22e ADDRESS
CLAY E. DURRETT, M.D.	236 VIRGINIA AVE. CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	JAN.5,1969	HILLCREST BURIAL PARK	CUMBWRLAND, MD.

24. FUNERAL DIRECTOR	ADDRESS	25a REG'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
BYRON KIGHT	CUMBERLAND, MD.	JAN 6 1969	[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 6-15-(4) 30M REV 1-68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A 45 (Rev. 1-69) 45M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00083 00083

1 DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
GEORGE	E.	SHOEMAKER	1	3	69	10:25 M

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN
MALE	WHITE	7-20-92	76 YRS		

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED X / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
PENNA.	USA		ALLEGANY Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	RETIRED FROM LUMBER CO. Retired Carpenter-	Lumber

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS YES / NO X	13e STREET AND NUMBER
MARYLAND	ALLEGANY	OLDTOWN		RT. 1, BOX 72-A

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
GEORGE		SHOEMAKER	ANNA	JANE	BAER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO		214-05-5611	HOSPITAL RECORD, 900 SETON DR., CUMB., MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Edema — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Lymphocytic Leukemia — 6 mos.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES / NO	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO	

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from Aug., 1968, to 1/3, 1969, that (I) (we) last saw the deceased alive on 1/3 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22c. SIGNATURE	M.D. DEGREE	ATTENDING PHYS ☑ / MED DIRECTOR ☐ / STAFF PHYS ☐	22c DATE SIGNED
			1/3/69

22d PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. PAGAN	1068 NAR., HWY. LA VALE, MD.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	Jan. 6, 1969	Davis Memorial Cemetery	Cumberland, Allegany, Md.

24 FUNERAL DIRECTOR ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
SCARPELLI FUNERAL HOME, 108 VA. AVE., CUMB., MD.	JAN 9 1969	Frances Yingling

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

00084

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00084

1. DECEASED-NAME (Type or Print)	First: Grace	Middle: Marie	Last: Shroyer	2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒	Month: 1	Day: 11	Year: 69	2b. HOUR: P M			
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: Sept. 27, 1879	6. AGE (In years last birthday): 89 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c. DATE PRONOUNCED DEAD: Month: January	Day: 12,	Year: 69	2d. HOUR: 4:00p M		
7a. BIRTHPLACE (State or foreign country): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Allegany							Md.	
10. CITY OR TOWN OF DEATH: Ellerslie	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Housewife	12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Ellerslie	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER							
14. FATHER'S NAME: First: Edward	Middle:	Last: Robb	15. MOTHER'S MAIDEN NAME: First: Emma	Middle:	Last: Corley						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	16b. SOCIAL SECURITY NO (If yes give war or dates of service): 214-22-6756	17. INFORMANT: Mrs. June Folk	ADDRESS: Cumberland, Md. RD								

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDD

DUE TO, OR AS A CONSEQUENCE OF

(b): CORONARY SCLEROSIS — --

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4129

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: January 12, 1969

ADDRESS (Street, city, town, or county): CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Jan. 15, 1969	Coons Cemetery	Hyndman, Somerset, Pa. RD1

24. FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Henry H. Zeigler, Hyndman, Pa.	JAN 17 1969	Charles Judge

VR A15ME (5)
10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00085

1 DECEASED-NAME (Type or print): First MARY; Middle ELIZABETH; Last SIEFERS

2a. DATE OF DEATH: Month JANUARY Day 29, Year 1969

2b. HOUR: AM 10:20

3 SEX: FEMALE

4 RACE: WHITE

5 DATE OF BIRTH: 11-20-92

6. AGE (In years last birthday): 76 YRS; IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN

7a BIRTHPLACE (State or foreign country): MARYLAND

7b CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. COUNTY OF DEATH: ALLEGANY Md

10 CITY OR TOWN OF DEATH: CUMBERLAND

11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL 900 SETON DRIVE CUMB., MD

12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): HOUSEWIFE

12b. KIND OF BUSINESS OR INDUSTRY:

13a USUAL RESIDENCE (Where deceased lived, if institution: Res dence before admission) STATE: MARYLAND

13b COUNTY: ALLEGANY

13c CITY OR TOWN: CUMBERLAND

13d INSIDE CITY LIMITS? YES ☒ NO ☐

13e STREET AND NUMBER: 520 CUMBERLAND STREET

14. FATHER'S NAME First WILLIAM Middle Last GRABENSTEIN

15. MOTHER'S MAIDEN NAME First ANNA G[redacted]R Middle Last GRABENSTEIN (Bellner)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)

16b. SOCIAL SECURITY NO. 212-12-8771

17 INFORMANT Address: SACRED HEART HOSP -900 SETON DRIVE CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Cardiac decompensation — APPROX. MATE INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO, OR AS A CONSEQUENCE OF
(b) metastatic Ca of endometrium — 1 yr
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Arteriosclerotic Ht. Disease

19a. DATE OF OPERATION: 2 yrs ago.

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Vag. Bleeding - D & C.

20a AUTOPSY? YES ☐ NO ☒

20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐

21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from 1-10, 1969, to 1-29, 1969, that (I) (we) last saw the deceased alive on 1-29, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: A. J. Mirkin M.D. DEGREE: ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22c. DATE SIGNED: 1-30-69

22d. PHYSICIAN'S NAME (Type): DR. A. J. MIRKIN

22e. ADDRESS: 115 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 2/1/69

23c. NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul Cem.

23d. LOCATION (City or Town) (County) (State): Cumb. Allegany Md.

24. FUNERAL DIRECTOR: Louis Stein Inc.

ADDRESS: Cumb. Md.

25a. RECD BY REGISTRAR DATE: FEB 3 1969

25b. REGISTRAR'S SIGNATURE: Charles Yonge

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4) 45M 1/69

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00086

1. DECEASED NAME (Type or Print) First	Middle	Last	2a DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month Day Year	2b. HOUR
Harvey	William	Simons	1-21-69 1968	8:00p M

3 SEX	4 RACE	5 DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN	2c. DATE PRONOUNCED DEAD Month Day Year	2d HOUR
Male	White	3/11/1887	81 YRS.					January 21, 1969 1968	8:30p M

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9 COUNTY OF DEATH
Penna	U.S.A.		Allegany Md

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY
Cumberland Rt #3		Retired Employee- P. E. Co	

13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Maryland	Allegany	Cumberland Rt3	YES [ ] NO [X]	

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Webster		Simons	Mary		Rice

16a WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No [redacted]	214-10-5341	Mrs. Lillian Simons	Rt 3- Bedford Road Cumberland, Maryla

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY SCLEROSIS — ---

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [ ] NO [X]

21a EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b TIME OF INJURY Month Day, Year HOUR A.M P.M 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D No	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Benedict Skitarelic M.D

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED JANUARY 21, 1969

ADDRESS(Street, city, town, or co) CUMBERLAND, MARYLAND

23a BURIAL, CREMATION REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	1/24/69	Hillcrest Burial Park	Cumberland Allegany Maryland

24 FUNERAL DIRECTOR	ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Silcox-Merritt Funeral Service	Cumberland, Md	JAN 23 1969	Assistant Judge

VR A15ME(R)
10M REV 1968

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 must be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00087 00087

1. DECEASED NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month Day Year	2b HOUR
ALBERT	C.	STURTZ	JAN. 17, 1969	4:00 A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
MALE	WHITE	07-31-~~85~~ 1895	73 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
PENNA.	USA		ALLEGANY Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	KELLY TIRE CO.	MFG. TIRES

13a. USUAL RESIDENCE (Where deceased lived / institution. Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
PENNA.	V	WELLERSBURG	YES [ ] NO [X]	BOX 3, WELLERSBURG, PENNA. 15564

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JOSEPH		STURTZ	LILLIE		~~GREY~~ Gary

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT	Address
NO	~~217-10-6617~~	217-10-6617	HOSPITAL CHART	SACRED HEART HOSPITAL CUMBERLAND, MD. 21502

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Coronary Occlusion — Interval between onset and death: —

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease — Interval between onset and death: 3yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

Congestive Heart Failure following Cont of Flu & Pneumonia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from March, 1966, to 1/17, 1969, that (I) (we) last saw the deceased alive on 1/16 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
J.A. Pagan	ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS [ ]	1/18/69 21502

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
J.A. PAGAN, M.D.	1068 NATL HWY LA VALE, CUMB., MD.

23a. BURIAL CREMATION REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Jan. 19, 1969	Wellersburg Cemetery	Wellersburg, Somerset, Pa.

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
ZIEGLAR FUNERAL HOME	HYNDMAN, PENNA.	JAN 23 1969	Charles Judge

1

00088

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00088

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS 45M

1. DECEASED-NAME (Type or print)	First: ROY	Middle: T	Last: TABLER	2a DATE OF DEATH: Month JANUARY Day 17 Year 1969	2b HOUR DIED: 7:50 PM	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 3-20-92	6. AGE (In years last birthday): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country): CUMB. MD.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md			
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MD.	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 622 OLDTOWN ROAD		
14. FATHER'S NAME First: AUGUSTA Middle: M. Last: TABLER	15. MOTHER'S MAIDEN NAME First: SAVILLA Middle:	Last: GLOVER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO: 705-05-8030	17. INFORMANT: MEMORIAL HOSPITAL, Address: CUMBERLAND, MD.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) [illegible]
DUE TO, OR AS A CONSEQUENCE OF (b) [illegible]
DUE TO, OR AS A CONSEQUENCE OF (c) [illegible]

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from [illegible], 19[illegible], to [illegible], 19[illegible], that (I) (we) last saw the deceased alive on [illegible] 19[illegible] and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS [X]	MED DIRECTOR [ ]	STAFF PHYS [ ]	22c. DATE SIGNED: 1/20/69
[signature]					

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. BLANE SCHINDLER	43 GREENE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Jan.20,1969	Sunset Memorial Park	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli,	Cumberland, Md.	JAN 21 1969	[signature]

Item 13 Film 409 2-14-69 ap

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

2008 — 00089

1

1. DECEASED NAME (Type or print)	First: BESSIE	Middle: E.	Last: TAYLOR	2a. DATE OF DEATH: JANUARY 23 1969	2b. HOUR: 9:25 PM
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 5-31-1897	6. AGE (In years last birthday): 71 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): W.VA.	7b. CITIZEN OF WHAT COUNTRY?: U. S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md		
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 101 First St CUMBERLAND NURSING HOME	
14. FATHER'S NAME: First GEORGE Middle E. Last CLARK	15. MOTHER'S MAIDEN NAME: First ELLEN Middle Last WILSON				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes or no or unknown: no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT: MEMORIAL HOSPITAL, CUMBERLAND, MD. (Address)			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Pneumonia Aspiration

DUE TO, OR AS A CONSEQUENCE OF (b): Cerebral Thrombosis

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerosis

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: (a) one (b) — (c) —

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from 1/17/69, 19___, to 1/23/69, 19___, that (I) (we) last saw the deceased alive on 1/23/69, 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ] — 22c. DATE SIGNED: 1/25/69

22d. PHYSICIAN'S NAME (Type): R.J.WMS. — 22e. ADDRESS: 122 S. CENTREST., CUMB. MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 1/27/69	23c. NAME OF CEMETERY OR CREMATORY: Philos	23d. LOCATION (City or Town): Westernport	(County) (State): Md.
24. FUNERAL DIRECTOR: E. S. Boat	ADDRESS: Westernport, Md.	25a. REC'D BY REGISTRAR DATE: JAN 30 1969	25b. REGISTRAR'S SIGNATURE: [signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A 45M - 7-69

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death

VR A15ME (5)
10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00090 00090

1 DECEASED NAME (Type or Print) First: Charles	Middle:	Last: Thompson	2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month Day Year: 1-8-69 19	2b HOUR: 3 A M			
3 SEX: Male	4 RACE: White	5 DATE OF BIRTH: April 14, 1894	6 AGE (In years last birthday): 74 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c DATE PRONOUNCED DEAD Month 1-8-69 Year 19	2d HOUR: 3 A M
7a BIRTHPLACE (State or foreign country): Maryland	7b CITIZEN OF WHAT COUNTRY?: U S A	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9 COUNTY OF DEATH: Allegany Md.				
10 CITY OR TOWN OF DEATH: Cumberland	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Memorial Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.): Retired Laborer	12b KIND OF BUSINESS OR INDUSTRY: B & O R R				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Maryland	13b. COUNTY: Allegany	13c CITY OR TOWN: Cumberland	13d INSIDE CITY LIMITS? YES [ ] NO [X]	13e STREET AND NUMBER: Route 2, Valley Road			
14. FATHER'S NAME First: Edward	Middle:	Last: Thompson	15. MOTHER'S MAIDEN NAME First: Mary	Middle: Eli	Last: Thomas		
16a. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: ---	17 INFORMANT: Memorial Hospital	ADDRESS			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): CORONARY OCCLUSION — APPROX MATE INTERVAL BETWEEN ONSET AND DEATH: HOURS

DUE TO, OR AS A CONSEQUENCE OF

(b): CORONARY SCLEROSIS — —

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4107

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [XX]

21a EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R F D. No	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [XX]
ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

22b DATE SIGNED: January 8, 1969

23a BURIAL, CREMATION REMOVAL (Specify): Burial	23b DATE: Jan. 10, 1969	23c NAME OF CEMETERY OR CREMATORY: Allegany County Cemetery	23d LOCATION (City or Town): Cumberland	(County): Alleg	(State): Md.
24 FUNERAL DIRECTOR: John J. Hafer, Jr.	ADDRESS: 230 Balto Ave. Cumberland, Md.	25a REC'D BY REGISTRAR DATE: JAN 10 1969	25b REGISTRAR'S SIGNATURE: Clarence Page		

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5 Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00091 00091

1 DECEASED NAME (Type or Print) First: Elise	Middle: Taliaferro	Last: Towler	2a DATE KNOWN [X] OF DEATH EST. [ ] Month Day Year: 1-18-69 19	7:50a M	2b HOUR		
3 SEX: Female	4 RACE: White	5 DATE OF BIRTH: June 22, 1908	6 AGE (In years last birthday) 60 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month Day Year: 1-18-69 19	7:50a M	2d HOUR	
7a BIRTHPLACE (State or foreign country): Maryland	7b CITIZEN OF WHAT COUNTRY?: USA	8 MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]	9. COUNTY OF DEATH: Allegany Md				
10 CITY OR TOWN OF DEATH: Cumberland	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Memorial Hospital-DOA	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Owner & Operator	12b. KIND OF BUSINESS OR INDUSTRY: Hotel Inn				
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE: Maryland	13b COUNTY: Allegany	13c CITY OR TOWN: Cumberland	13d INSIDE CITY LIMITS? YES [X] NO [ ]	13e STREET AND NUMBER: 229 Baltimore Avenue			
14 FATHER'S NAME First: Ernest	Middle: Hunter	Last: Taliaferro	15 MOTHER'S MAIDEN NAME First: Ella	Middle: Hartley	Last: Cave		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17 INFORMANT: Lindsay C. Taliaferro, Sr.	ADDRESS: Pheonix, Maryland				

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY SCLEROSIS — ----

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]

21a EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a **I certify** that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER XX

22b. DATE SIGNED: January 18, 1969

ADDRESS (Street, city, town, or county): Cumberland, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	1/21/69	Hillcrest Burial Park	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a RECD BY REGISTRAR	25b REGISTRAR'S SIGNATURE
Charles E. Hafer, 230 Balto. Ave., Cumberland, Md.	JAN 21 1969	Charles Jaggs

VR A15ME (5)
10M REV 1/68

4-1

1969 ~

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00092

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print): First Hattie; Middle Mae; Last Valentine
2a. DATE OF DEATH: Month Jan. Day 8 Year 1969 @ 12:50 P.M.
2b. HOUR: 12:50
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: 3/1/1886
6. AGE (In years last birthday): 82 YRS. IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): Pa.
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: Allegany Md
10. CITY OR TOWN OF DEATH: Cumberland
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Allegany Co. Infirmary
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Housewife
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Md.
13b. COUNTY: Allegany
13c. CITY OR TOWN: Cumberland
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: Unk.
14. FATHER'S NAME First Samuel Middle Last Hughes
15. MOTHER'S MAIDEN NAME First Mary Jane ??? Middle Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16b. SOCIAL SECURITY NO: 220-10-2442
17. INFORMANT: Mr. Gilbert T. Garlitz, Cumberland, Md. Son

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 days
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) Gen. Arteriosclerosis — years
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from Sept 5, 1968, to Jan 6, 69, that (I) (we) last saw the deceased alive on Jan 4 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: George M. Simons M.D. DEGREE: ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22c. DATE SIGNED: 1/7/1969
22d. PHYSICIAN'S NAME (Type): George M. Simons, M. D.
22e. ADDRESS: Memorial Hospital, Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Jan. 9, 1969
23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR: James F. Scarpelli, Cumberland, Md.
25a. RECD BY REGISTRAR DATE: JAN 10 1969
25b. REGISTRAR'S SIGNATURE: Florence Judge

VR A15
30M REV 7-68

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 12-68

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00093 00093

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First: Grace	Middle: --	Last: Vang	2a. DATE OF DEATH: Jan. Month 18, Day 69 Year	2b. HOUR: 8:20 P.M.	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: Jan. 31, 1886	6. AGE (In years last birthday): 82 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): New York	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md.		
10. CITY OR TOWN OF DEATH: Cumberland,	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Cumb. Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife.	12b. KIND OF BUSINESS OR INDUSTRY: Own home		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland,	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 224 Schley St.	
14. FATHER'S NAME First: Frank	Middle: --	Last: Spaulding	15. MOTHER'S MAIDEN NAME First: Alida	Middle: --	Last: Teeter
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No,	16b. SOCIAL SECURITY NO.: 220-44-3962	17. INFORMANT: Mrs. Durand T. Becker	Address: P.O. Box 175 Eagle Pass Texas, 78852		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Terminal bronchial penumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 week

4124

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic cardiovascular disease with generalized arteriosclerosis, chronic. — 5 years

DUE TO, OR AS A CONSEQUENCE OF (c): Chronic brain syndrome. — 5 years.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Latent depressed state.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. I certify that (I) (~~this hospital~~) attended the deceased from 7 October, 1959, to 18 January, 1969, that (I) (~~he~~) last saw the deceased alive on 17 January 1969, and that in (my) (~~his~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~he~~) (did) (did not) view the body after death.

22b. SIGNATURE: W. A. Van Ormer, M.D.	DEGREE: ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐	22c. DATE SIGNED: 20 January 1969		
22d. PHYSICIAN'S NAME (Type): W. A. VanOrmer, M. D.	22e. ADDRESS: 122 So. Centre St. Cumberland, Md.			

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 1/22/69	23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park,	23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany Md.	
24. FUNERAL DIRECTOR: H. Wayne George	ADDRESS: Cumberland, Maryland	25a. RECD BY REGISTRAR DATE: JAN 27 1969	25b. REGISTRAR'S SIGNATURE: Gilbert L. Yeager	

1

0069

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00094

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Mary	Ann	Webel	Jan. 7, 69	4:50 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
Female	White	Nov. 17, 1891	77 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. COUNTY OF DEATH
New York,	U. S. A.		Allegany Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland,	Memorial Hosp.	Clerk,	Dept. Store

13a. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany	Cumberland,	YES ☒ NO ☐	699 Gephart Dr.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Richard	--	Jones	Mary	--	Donovan

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT	Address
No,	111-30-4793	Mrs. Marie Hartnett	132-40 220 St. Gardens, Springfield N.Y.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cancer of lung Bronch	months
DUE TO, OR AS A CONSEQUENCE OF (b)	Cancer of intestines	years
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from Jan. 4, 19 69, to Jan. 7, 19 69, that (I) (we) last saw the deceased alive on Jan. 7 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
[signature]					Jan. 8, 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Blane M. Schindler, M. D.	43 Greene St. Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	1/11/69	St. John's Cem.	Middle Village Queen's N. Y.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
H. Wayne George 202 Greene St. Cumberland, Md.	JAN 10 1969	[signature]

VR A15 (4) 30M REV 1/68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH

0669 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00095

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1969

1 DECEASED NAME (Type or Print) First	Middle	Last
JANNIE		WELLS

2a DATE KNOWN OF DEATH [X] / ESTIMATED [ ] Month Day Year: Jan. 4, 1969 — 2b HOUR: 6:35 AM

3. SEX	4 RACE	5 DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
Female	Negro	July 21, 1906	62 YRS		

2c. DATE PRONOUNCED DEAD Month Day Year: January 4, 1969 — 2d HOUR: 6:35a M

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
South Carolina	U.S.A.	WIDOWED [X]	Allegany Md

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Cumberland	Memorial Hospital-DOA	None	

13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
South Carolina	Florence	Florence	YES [X] NO [ ]	104 Kemp St.

14 FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Horace		Lane	Roxanna		Kelly

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17. INFORMANT ADDRESS
No	Unk.	Arie Pickins Florence, South Carolina

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY — IMMEDIATE CAUSE (a): CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO, OR AS A CONSEQUENCE OF (b): CORONARY SCLEROSIS ----

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R F D No.	City or Town	County	State

22a **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: January 4, 1969

ADDRESS (Street, city, town, or county)

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Jan. 8, 1969	Union Cemetery	Florence, Florence, S. Car.

24 FUNERAL DIRECTOR ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Philip B. Wendt 121 Memorial Ave. Cumb., Md.	JAN 8 '69	[illegible]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15(2)
30M REV.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00096

1 DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b HOUR
ANNABELLE	(BRODE)	WHETSTONE	JANUARY	7,	1969	M

3. SEX	4. RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN
FEMALE	WHITE	OCT. 15, 1899	69 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH
MARYLAND	U.S.A.		ALLEGANY Md.

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY
FROSTBURG	58 LINDEN STREET	HOUSE WIFE	

13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
MARYLAND	ALLEGANY	FROSTBURG	YES ☒ NO ☐	58 LINDEN STREET

14 FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
PHILLIP		BRODE	ELIZABETH		SLEEMAN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17 INFORMANT Address
	214-07-5362	PETER G. WHETSTONE, FROSTBURG, MD.

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arterio - Sclerotic heart disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — 4123

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R F D No.	City or Town	County	State

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from 6-15, 1968, to 1-7, 1969, that (I) (we) last saw the deceased alive an 1-4 1969, and that in (my) (~~our~~) apinion death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (~~did not~~) view the bady after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☒	MED DIRECTOR ☐	STAFF PHYS. ☐	22c DATE SIGNED
H.C. Diehl M.D					1-8-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
H.C. Diehl, M.D.	FROSTBURG, Md.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	JAN. 9, 1969	FBG. MEMORIAL PARK	FROSTBURG, MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
JOSEPH R. DURST, FROSTBURG, MD. 21532	JAN 9 1969	Charles Yuggo

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3009, 30097

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Rawlings
c. LENGTH OF STAY IN 1b: 10yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Route #1, Rawlings

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Rawlings
d STREET ADDRESS: Route #1, Rawlings
e S RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John — Middle Wesley — Last Whetzel

4 DATE OF DEATH: Month January — Day 6th — Year 1969

5. SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: June 4th, 1871
9 AGE (In years last birthday): 97 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rt Coal Miner
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Petersburg, W.Va.
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Israel Whetzel
14 MOTHER'S MAIDEN NAME: Mary Jane Watts

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 236-78-5335
17. INFORMANT: Address: Cilvie O. Whetzel, Box 64, Keyser W. V

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
4109
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): CORONARY SCLEROSIS — ---
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO XX

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M D
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town or county): Cumberland, Maryland
22. DATE SIGNED: 1/6/1969

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: JAN 8, 1969
23c NAME OF CEMETERY OR CREMATORY: Kalbaugh Cemetery
23d LOCATION (City or Town) (County) (State): Elk Garden W Va

24 FUNERAL DIRECTOR: [illegible] Kotnik, Keyser W Va
ADDRESS
25a REC'D BY REGISTRAR DATE: JAN 8 1969
25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00098

1 DECEASED-NAME (Type or print): First ISAAC Middle M Last WHISNER

2a. DATE OF DEATH: Month 1 Day 23 Year 69

2b. HOUR 7:15 AM

3 SEX: MALE

4 RACE: WHITE

5. DATE OF BIRTH: 3-1-78

6 AGE (In years last birthday): 90 YRS

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (State or foreign country): WEST VIRGINIA

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. COUNTY OF DEATH: ALLEGANY Md

10 CITY OR TOWN OF DEATH: CUMBERLAND

11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): RETIRED Maintenance-Municipal

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND

13b. COUNTY: ALLEGANY

13c. CITY OR TOWN: CUMBERLAND

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET AND NUMBER: 16 POTOMAC ST.

14. FATHER'S NAME First Middle Last: Isaac Whisner

15. MOTHER'S MAIDEN NAME First Middle Last: Julia ?

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: no (If yes give war or dates of service)

16b. SOCIAL SECURITY NO

17. INFORMANT: MEMORIAL HOSPITAL Address: CUMBERLAND MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) [illegible]

DUE TO, OR AS A CONSEQUENCE OF (b) [illegible]

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY? YES ☐ NO ☐

20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from [illegible], 19[illegible] to [illegible], 19[illegible], that (I) (we) last saw the deceased alive on [illegible], 19[illegible], and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE [signature] DEGREE ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22c. DATE SIGNED 1/24/69

22d. PHYSICIAN'S NAME (Type) DR. B. SCHINDLER

22e ADDRESS CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b DATE Jan.25,1969

23c NAME OF CEMETERY OR CREMATORY Sunset Memorial Park

23d LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS James F. Scarpelli, Cumberland, Md.

25a RECD BY REGISTRAR DATE JAN 27 1969

25b REGISTRAR'S SIGNATURE [signature] Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4) 45M 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00099 **CERTIFICATE OF DEATH** 00099

1. DECEASED-NAME (Type or print)	First: ROGER	Middle: C.	Last: WILLISON	2a. DATE OF DEATH: JANUARY (Month) Day 2 Year 69	2b. HOUR: 3:30 A	
3 SEX: MALE	4. RACE: WHITE	5 DATE OF BIRTH: 6-3-12	6. AGE (in years last birthday): 56 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country): MD.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. COUNTY OF DEATH: ALLEGANY			
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD.	13b. COUNTY: ALLEGANY	13c CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e STREET AND NUMBER: YMCA 217 BALTIMORE ST.		
14. FATHER'S NAME First: JOHN	Middle	Last: WILLISON	15. MOTHER'S MAIDEN NAME First: ISORA	Middle	Last: DRENNING	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes	(If yes, give war or dates of service): WW II	16b SOCIAL SECURITY NO	17 INFORMANT: MEMORIAL HOSP.	Address: CUMBERLAND, MD.		

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) [illegible]
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I **certify** that (I) (this hospital) attended the deceased from [illegible], 19[illegible]; to [illegible], 19[illegible]; that (I) (we) last saw the deceased alive on [illegible], 19[illegible]; and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE [illegible] DEGREE: ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22c DATE SIGNED: 1/2/69

22d. PHYSICIAN'S NAME (Type): BLANE M. SCHINDLER, M.D. 22e. ADDRESS: 43 GREENE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: 1/5/69	23c NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Pk.	23d LOCATION (City or Town): Cumberland	(County): Allegany	(State): Md.
24. FUNERAL DIRECTOR: Lewis Stein Inc.	ADDRESS: Cumb. Md	25a REC'D BY REGISTRAR DATE: JAN 6 1969	25b. REGISTRAR'S SIGNATURE: J. Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (Rev. 4SM - 1-68)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

30130 — 00100 PM

1 DECEASED NAME (Type or print)	First: THORNTON	Middle: NMI	Last: WILSON	2a. DATE OF DEATH: Month 1 Day 14 Year 69	2b. HOUR: 6:30 PM
3 SEX: MALE	4. RACE: WHITE	5 DATE OF BIRTH: 12-14-1909 12-14-09	6 AGE (In years last birthday): 59 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
7a BIRTHPLACE (State or foreign country): MARYLAND	7b CITIZEN OF WHAT COUNTRY?: USA	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9 COUNTY OF DEATH: ALLEGANY Md		
10 CITY OR TOWN OF DEATH: CUMBERLAND	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL	12a USUAL OCCUPATION (Kind of work done during most of working life even if retired): RAILROAD Machinist Helper	12b KIND OF BUSINESS OR INDUSTRY: RR		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MARYLAND	13b COUNTY: ALLEGANY	13c CITY OR TOWN: CUMBERLAND	13d INSIDE CITY LIMITS? YES ☐ NO ☒	13e STREET AND NUMBER: ROUTE 4 -OLDTOWN ROAD	
14 FATHER'S NAME: First SAMUEL Middle Last THORNTON	15 MOTHER'S MAIDEN NAME: First ADELINE Middle TWIGG Last THORNTON				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17 INFORMANT: SACRED HEART HOSPITAL	Address: 900 SETON DRIVE CUMBERLAND, MARYLAND		

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a): Pulmonary edema bilateral — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 12 hrs

DUE TO, OR AS A CONSEQUENCE OF: (b) Small bowel Infarction due to venous Thrombosis — . 12 hrs

DUE TO, OR AS A CONSEQUENCE OF: (c) Massive Gastrointestinal Hemorrhage from duodenal ulcer — 4 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

5320 +

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): None

19a. DATE OF OPERATION: 1/13/69	19b CONDITION FOR WHICH OPERATION WAS PERFORMED: Bleeding duodenal ulcer	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that (I) (this hospital) attended the deceased from 1/13, 1969, to 1/14, 1969, that (I) (we) last saw the deceased alive on 1/14 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: Andrew Stasko MD	DEGREE: ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐	22c DATE SIGNED: 1/15/69	
22d. PHYSICIAN'S NAME (Type): DR. ANDREW STASKO	22e ADDRESS: 401 DECATUR ST -CUMBERLAND, MD. 21502		

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: Jan. 17, 1969	23c NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park	23d LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR: James F. Scarpelli, Cumberland, Md.	ADDRESS	25a. REC'D BY REGISTRAR DATE: JAN 20 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00101 — 00101

1 DECEASED NAME (Type or Print)	First: Sharon	Middle: Marelene	Last: Wilt	2a DATE KNOWN OF DEATH ESTIMATED XX	Month Day Year: 1-17-69	19	2b HOUR: 11:30 P M
3 SEX: Female	4 RACE: White	5 DATE OF BIRTH: April 14,1950	6 AGE (in years last birthday) YRS.: 18	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c DATE PRONOUNCED DEAD: Month Day Year: 1-19-69	19	2d HOUR: 8:00a M
7a BIRTHPLACE (State or foreign country): Maryland	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md				
10 CITY OR TOWN OF DEATH: Rural-Near Westernport	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Not Employeed	12b KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Maryland	13b COUNTY: Allegany	13c. CITY OR TOWN: Westernport	13d INSIDE CITY LIMITS? YES ☒ NO ☐	13e STREET AND NUMBER: 214 Poplar St.			
14 FATHER'S NAME First: Richard	Middle	Last: Wilt	15 MOTHER'S MAIDEN NAME First: Margaret	Middle	Last: Broadwater		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)	16b SOCIAL SECURITY NO.: 212-54-8044	17 INFORMANT: Evelyn Weicht	ADDRESS: Everett, Pa.				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

873 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Asphyxiation	About 2 Hrs.
DUE TO, OR AS A CONSEQUENCE OF (b)	Carbon Monoxide Poisoning	"
DUE TO, OR AS A CONSEQUENCE OF (c)	(Exhaust of Auto)	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Exposure in near freezing temperature

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
	About 11:30PM 1-17-69	In parked car with engine running

21d INJURY OCCURRED	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State
WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Road	Mill run road near Westernport, Allegany, Maryland

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒ Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b DATE SIGNED: JANUARY 19, 1969

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	Jan. 21, 1968	Tasker Cemetery	Cross Mineral W.Va.

24 FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
E. L. Boal	Westernport, Md.	JAN 22 1969	Charles Yonge

VR A15ME (5)
10M REV 1-68

1

FOR STATE HEALTH DEPT.

Item 5 Film 3 0102

1/17/69 K 0102

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00102

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print) First	Middle	Last	2a DATE OF DEATH KNOWN ☐ ESTIMATED ☐ Month Day Year	2b HOUR A.M/P.M
Loretta		Windemuth	Jan. 9, 1969	8:05 M

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month Day Year	2d HOUR A.M/P.M
Female	White	Jan. 17, 1890	78 YRS			Jan. 9 1969	8:05 M

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Cumberland Md.	U.S.A.		Allegany Md

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY
Cumberland Md.	D.O.A. Memorial Hospital	Housewife.	

13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Maryland	Allegany	Cumberland.	YES ☐ NO ☒	R.F.D. #5 Cumberland Md.

14 FATHER'S NAME First Middle Last	15 MOTHER'S MAIDEN NAME First Middle Last
George Windemuth	Elizabeth Anna Mudge.

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17 INFORMANT ADDRESS
No		Mrs. Albert Klavuhn. R.F.D. #5 Cumb. Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) CORONARY OCCLUSION — APPROX. INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY SCLEROSIS

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY?
		YES ☐ NO ☒

21a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b DATE SIGNED: Jan 9, 1969

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	1/12/69	St. Luke's Cem.	Cumberland Allegany Md.

24 FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Louis Stein Inc.	Cumb. Md.	JAN 13 1969	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PMC-POL 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15ME (5)
10M REV 1/68

1

FOR STATE HEALTH DEPT.

Item2 Film6408
1/17/69 klb 00103

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00103

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)	First: Rose	Middle: May	Last: Wolford				2a. DATE KNOWN OF DEATH ESTIMATED ☐	Month: Jan.	Day: 2	Year: 1969	2b. HOUR: 7 AM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: Aug. 5, 1890	6. AGE (In years last birthday): 78 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		2c. DATE PRONOUNCED DEAD	Month: January	Day: 2	Year: 1969	2d. HOUR: 7 AM
7a. BIRTHPLACE (State or foreign country): West Va.	7b. CITIZEN OF WHAT COUNTRY?: U S A	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Allegheny Md.								
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Memorial Hosp	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: House								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: West Va.	13b. COUNTY: Hampshire	13c. CITY OR TOWN: Augusta	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: ---							
14. FATHER'S NAME First: John W.	Middle:	Last: Hott	15. MOTHER'S MAIDEN NAME First: Jermina (Hott)	Middle:	Last: Hott						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214-52-1825	17. INFORMANT: Elmer Wolford	ADDRESS: Augusta, West Va.								

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): SHOCK — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 HOUR

DUE TO, OR AS A CONSEQUENCE OF

(b): EXANGUINATION — 〃

DUE TO, OR AS A CONSEQUENCE OF

(c): PEPTIC ULCER — ---

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5339

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5400

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: January 2, 1969

ADDRESS(Street, city, town, or county): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Jan. 5, 1969	Malick Cemetery	Augusta, Hampshire WVa.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Wade H. McKee	Augusta, W Va	JAN 6 1969	J Charles Judge

VR AT5ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00104

CERTIFICATE OF DEATH

00104

1. DECEASED NAME (Type or print): First MILDRED Middle Martha Last WORKMAN
2a. DATE OF DEATH: Month 1 Day 28 Year 69
2b. HOUR: 12:35 PM
3. SEX: FEMALE
4. RACE: WHITE
5. DATE OF BIRTH: Apr. 24, 1894
6. AGE (In years last Birthday): 74
IF UNDER 1 YEAR: MONTHS 9 DAYS 2
IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: ALLEGANY Md
10. CITY OR TOWN OF DEATH: CUMBERLAND
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): House Wife
12b. KIND OF BUSINESS OR INDUSTRY: Home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: W. VIRGINIA
13b. COUNTY
13c. CITY OR TOWN: KEYSER
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: 50 N. MAIN ST.
14. FATHER'S NAME First FULLER Middle Last BARNARD, Sr.
15. MOTHER'S MAIDEN NAME First ADA Middle Cannon Last ATKINS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): No
16b. SOCIAL SECURITY NO.: None
17. INFORMANT: Memorial Hospital
Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis with Brain metastase — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 months
DUE TO, OR AS A CONSEQUENCE OF
(b) Adeno-Carcinoma, hepatic flexure Colon, — 13 months
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1581
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I **certify** that (I) (this hospital) attended the deceased from 2 Jan., 1969, to 26 Jan., 1969, that (I) ~~(we)~~ last saw the deceased alive on 26 Jan. 1969, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE: W. A. VanOrmer, M.D.
DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED: 1-27-69
22d. PHYSICIAN'S NAME (Type): W.A.VanOrmer M.D.
22e. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Jan. 29, 69
23c. NAME OF CEMETERY OR CREMATORY: Queens Point Cem.
23d. LOCATION (City or Town) (County) (State): Keyser Mineral W.Va.
24. FUNERAL DIRECTOR: Harold W. McKenzie
ADDRESS: Keyser, W.Va.
25a. REC'D BY REGISTRAR DATE: JAN 31 1969
25b. REGISTRAR'S SIGNATURE: Blanche Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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